Mental Welfare Commission for Scotland

Report on unannounced visit to:

Claythorn House, Gartnavel Royal Hospital, 1055 Western Road, Glasgow, G12 0XH

Date of visit: 11 February 2026

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

Where we visited

Claythorn House is a ten-bedded, mixed-sex, acute assessment and treatment unit for individuals with intellectual disability, mental ill-health, and behaviours that challenge; it is situated on the Gartnavel Royal Hospital site.

When we visited Claythorn House in 2024, we were told that two of the original 12 beds had been temporarily reduced as a measure to mitigate risk associated with higher clinical need and the increase in interpersonal aggression in the service.

For this visit, senior staff told us that the service was now operating with a maximum capacity of 10. On the day, there were nine people in the ward. One person was receiving active assessment and treatment; the remaining eight people were considered to be ready for discharge, but their discharge was delayed.

We last visited this service in September 2024 and made one recommendation about the need to prioritise the soundproofing work in the unit. We have heard about a number of adaptations that have been made to the ward since that time.

On the day of this visit, we wanted to follow up on the previous recommendation and to hear about the progress that was being made with those individuals whose discharges were delayed.

Who we met with

We met with, and reviewed the care of five people, four who we met with in person and one whom we reviewed the care notes of. We also met with/spoke with three relatives.

We spoke with the head of service, the service manager, the senior charge nurse and the professional lead nurse. We also spoke with six members of nursing staff, the clinical psychologist and two members of the occupational therapy team.

Commission visitors

Sheena Jones, consultant psychiatrist

Inez Kohl, nursing student

Mary Leroy, nursing officer

What people told us and what we found

One person told us that they were happy in Claythorn House. They said that the nursing staff helped them. They told us that they had no worries about being in hospital but asked us if we knew when they would leave.

One person told us that it was “not fair” how long they had been in hospital and asked us what we could do to make sure that they were discharged.

One family member told us that the staff were very good and that they felt part of their relative’s care team. They said that the staff went “above and beyond” for their relative.

Another family member told us that communication with the staff was “generally good” and that they knew the staff team well. They said that they had daily contact with the nursing team, who would provide updates at that time. They also said that a consistent approach from staff could be an issue and that there were times when the service appeared to struggle with staffing levels. They said that the staff team worked hard to keep their relative safe and support them when they were distressed and agitated.

One family member told us that “there are a handful of really nice staff in the unit” and one member of staff that they had a particularly good relationship with. They went on to say that some of the staff “don’t know how to handle people”, like their relative; they said the lack of consistency and failure to follow the person’s preferred routines led to them becoming upset and this then had an impact on their activities for the day.

We heard from nursing staff that the levels of violence and aggression in the ward were high. We heard that staff were spat at and that they had suffered injury to head and body from assaults. They were concerned that this had become “normal”. We were told that some staff could feel intimidated when people were aggressive and that some staff had left because of this.

Nursing staff told us that people were forced to share their living areas with people they would not choose to live with and that the distress and aggression from some individuals was upsetting for others and increased the trauma faced by all when their peers retaliated.

Nursing staff told us that there were times when they had to walk individuals away from others who were distressed and aggressive. They were concerned that they were having to restrict people to keep them safe. They were also concerned at how long people were staying in hospital due to a lack of appropriate supported accommodation options in the community.

We heard from various members of the multidisciplinary team (MDT) about how little room there is in Claythorn House, that there was a need for quiet and calm areas for people to engage in sensory and therapeutic activities and that there was a need for larger safe, outdoor space where people could freely move around. There is a small, enclosed garden that can be accessed via the ward but is not large enough for some patients.

We heard from other members of the MDT that “nursing staff are invested” in the care and treatment of people in the ward and “always go above and beyond”.

Another member of the MDT told us that the nursing staff are enthusiastic and continue to volunteer to take on new work that they think will benefit individuals in the service.

One staff member spoke about feeling supported by their colleagues and being able to ask for help from colleagues, including the service manager, when they felt uncertain or overwhelmed.

Care, treatment, support, and participation

Care records

Care records are kept in different places in Claythorn House. There was an electronic care record system in use called EMIS. We were told by nursing staff that the care plan sections in the EMIS system were not used as this did not meet the needs of the service. We heard about a pilot project that had just started and was using a learning disability nursing assessment tool. We look forward to hearing more about the progress with this when we next visit.

Current care plans, risk assessment and management documents were held on a separate shared drive. Additional information, including Mental Health Act paperwork, was kept in paper files. Information about medication prescribing and administration was held on the electronic medication prescribing system, HEPMA.

We were able to access information easily from across these systems for each individual. On both electronic systems there were helpful alerts that highlighted important information about individual’s mental and physical health, legal processes that were in place and any specific risks or concerns.

We found a wide range of detailed and person-specific care plans for each individual that related to physical health, mental health, developmental needs, communication, positive behaviour support, and behaviour management strategies. These were current and reflected each person’s individual needs; they were regularly reviewed and updated.

With regards to physical health, we found a wide range of investigations and care plans in each person’s records, for example, management of epilepsy, diabetes, eating and swallowing care plans.

We could see that each person’s preferences were considered in the care plans and that families and carers were consulted and involved.

It was evident from care records that a range of professionals were contributing to care and treatment, with regular involvement of psychology, occupational therapy (OT), and speech and language therapy. We saw detailed multidisciplinary assessments, positive behaviour support plans, and behavioural strategies in the format of a ‘Traffic Light System’ that detailed how each person should be supported at any given time, depending on how they were feeling.

We saw detailed risk assessment and management plans that contained relevant historical and current information, with additional risk care plans for specific situations that were relevant to each individual and that linked with their positive behaviour support plans.

We also heard about work being progressed by the OT team in relation to people’s sensory profiles, and how that could support the right activity at the right time for each person; we look forward to seeing progress in relation to this.

We spoke with the service manager about processes to progress discharge for people whose discharge was delayed. We were told that there was a weekly bed management meeting in the service, where discharge plans were discussed. The service manager contacts the relevant social care service manager and heads of service where there are issues identified. The service manager also attends service-wide meetings in relation to discharge planning for people who are delayed in hospital and for people who require complex care and support arrangements. We also heard that the organisation publishes annual reports on activity and discharge to ensure there is clear visibility of delayed status and use of the service.

Multidisciplinary team (MDT)

The MDT included nursing staff (charge and staff nurses), healthcare assistants, an activity nurse, psychiatry, psychology, occupational therapy (OT), speech and language therapy, dietetics, pharmacy and physiotherapy.

We heard from the service manager that while there were no current nursing vacancies in the service, there was ongoing work in relation to workforce requirements, given the high levels of continuous interventions and restrictive practices. We heard that the number of nursing staff had increased in the previous year and the intention was to recruit additional staff in line with common staffing method outcome with a focus on registered nurses.

We were also told that the service continues to rely on bank staff but that every effort is made to use staff who are familiar with the service.

We saw regular recording of weekly MDT meetings where it was noted who was in attendance. There was a summary of the person's progress over the previous week, and information shared by family members. There was a record of the team's discussion, clear outcomes and actions to be achieved which were relevant to the person's care plans. Discussion about discharge took place at every meeting this included escalation when plans are not progressing.

We also heard from members of the MDT about additional core group and care planning meetings where specific aspects of a person's care and treatment were prioritised for team discussion or to support discharge planning.

The unit has access to 24-hour, on-site psychiatry cover through the duty system at Gartnavel Royal Hospital. There was input from a GP three times a week and GP urgent medical cover is provided during normal working hours. The visiting GP knew the people in Claythorn House well, and this continuity was found to be valuable. Urgent medical and psychiatric cover out with normal working hours was provided by the duty doctor at Gartnavel Royal Hospital.

We spoke with the clinical psychologist and heard that every person in the ward has a detailed positive behaviour support (PBS) plan. We were told that these plans were being reviewed to ensure that the most relevant information was available to staff and to ensure that proactive and preventative approaches were prioritised. The clinical psychologist also told us about their support to the MDT in relation to reflective practice and psychological formulation.

We heard from the OT team about the work that they had undertaken in relation to people's sensory needs and the ward environment. We heard that the sensory work would continue to develop and the intention to create 'sensory champion' roles in the service to further develop skills in this area. They also spoke about work to consider how the different MDT care plans could be streamlined including sensory profiles, sensory ladders, PBS care plans, and traffic light systems.

Nursing and MDT staff told us about the need to increase knowledge and skills in the service. We heard that nursing staff were undertaking postgraduate training in autism and in PBS. We also heard about a training programme that had been developed with support from the MDT. Over a period of three months, development days were being offered to allow as many staff to attend as possible. Topics included PBS, autism, risk, trauma informed practice, communication, and food and fluid management.

Some nursing staff also told us that their professional supervision did not always happen. They spoke about supervision being planned and then being cancelled due to the level of clinical activity in the service and the need to respond to situations as they arose. Professional supervision is important in supporting good practice and can enhance person-centred care and well-being; it is a priority given the current level of clinical need, the levels of violence and aggression, and the use of restrictive practice in the service.

We were told by professional nurse lead that there is a regular audit of nursing supervision in the service and that this had not highlighted any concerns to date. We were advised that the audit would be repeated in the near future and any issues that are identified will be addressed.

Recommendation 1:
The senior charge nurse and service manager must ensure nursing supervision occurs at agreed intervals and undertake an audit of the same.

Use of mental health and incapacity legislation

At the time of our visit, all nine people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) and subject to guardianship orders under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act).

All documentation relating to the Mental Health Act and the AWI Act, including copies of guardianships were in place, reviewed and correct. These documents were held in paper form in a folder in the unit which allowed them to be accessed easily and reviewed. The alerts on the electronic systems ensured that the care team were aware that there were legal powers in place.

We heard about one recent incident which had led to an adult concern being raised with the local authority under Adult Support and Protection (Scotland) Act, 2007 (ASP Act). We had already been notified about this incident by the relevant social work team and will continue to seek updates in relation to this.

We saw evidence through care records and daily progress notes of the involvement of people and families in care planning and the involvement of advocacy to support people with meetings when this was requested.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3) under the Mental Health Act were in place where required, corresponded to the medication being prescribed and were in date.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker, record this on the form and complete a treatment plan. At the time of our visit, eight people had a section 47 certificate in place. The certificates and treatment plans that we reviewed were detailed and relevant. In one case the treatment plan had recently expired, and we raised this with the service at the time of our visit.

Any person who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. We did not find any named person documentation during this visit, which would be in keeping with the impact of developmental disability on people's decision-making capacity in the service.

Rights and restrictions

Claythorn House operates a locked door policy due to the vulnerability of the patient group.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where an individual is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place under the Mental Health Act, we found that all paperwork was available in the folder containing all legal documentation.

At the time of our visit, seven people were assessed as requiring an increased level of continuous intervention, with six people having one-to-one support and one person requiring two-to-one support from the nursing team. Additionally, two people were allocated a 'responder'. This was an identified member of staff for an individual who may need additional support at various points throughout the day.

There were individualised and detailed risk assessments in place that outlined arrangements for time off the ward and the support required to facilitate this safely. We saw evidence that people were regularly supported to take part in a wide range of activities out with the ward.

We reviewed care plans regarding the need for increased continuous intervention and found them to be person-centred, with a clear rationale for the restriction being in place, and with regular reviews documented.

Seven people in the ward were also subject to periods of seclusion in their bedrooms at times of significant distress and agitation. This ranged from one person rarely being secluded to individuals having multiple episodes of seclusion each day. We reviewed the seclusion care plans and found them to be clear regarding the seclusion process and regularly reviewed. The use of seclusion was considered in conjunction with risk assessment and management plans, positive behaviour support plans and the traffic light systems referred to above.

In addition to the use of seclusion, we also heard about the use of restraint in Claythorn House. This was used when people were placing themselves or others at risk. Since our visit, we have requested data about the use of restraint or seclusion over the last three months, to further review the use of restrictive interventions in the service.

We heard from senior managers about work that is being undertaken by the MDT to review the use of restraint and seclusion, with the intention of reducing the use of restrictive interventions. We saw documentation in people's care records following a MDT review of specific incidents. This included information about potential triggers and contributing factors, the actions of staff and potential alternative approaches. The MDT also considered the incident in conjunction with the person's care plans, good practice guidance and how people and staff were supported after the incident.

When we are reviewing patients' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We did not see any advance statements at the time of our visit, due to the majority of people in the ward having been considered to lack capacity in relation to their health and well-being.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment.

Activity and occupation

At the time of our last visit in September 2024, we heard about the work that the service had done to embed a culture where regular activities, including outdoor and community activities, were prioritised.

Claythorn House has a dedicated activity co-ordinator in post who ensures that each person has their own activity planners, which included a range of social, recreational, cultural and rehabilitation activities.

There is also a daily staffing huddle which considers staffing requirements in order to prioritise people's activities each day.

When we reviewed people's electronic care records, we saw that nursing staff were regularly recording when they had one-to-one meetings with individuals and their activities each day.

During the recent visit we saw the activity nurse supporting people in the ward during periods of anxiety, with music and dance.

We heard from the MDT that community activities were prioritised wherever possible to support people to have time out of the ward, providing a break from the ward environment and the opportunity to engage in their preferred activities. We saw people going out from the ward with staff and family members.

We spoke with the OT team and heard about the work that they also do to understand each person's interests and preferences which informs what activities they can access in their own community during their admission and to support activities after discharge. When people are too unwell to access the community, the team will then consider how they can replicate those activities in Claythorn House.

The physical environment

Claythorn House is a long, single-story building which is entered through security doors at one end. There are staff rooms, catering space and a small reception office inside the main entrance. The main ward area is accessed through locked, double doors next to the reception area.

There is one main corridor that runs along the middle of the ward, with rooms accessed from either side. The corridor has little natural light and noise carries along the length of the ward.

The middle section of the ward has a large dining and lounge area, a separate TV room, a therapy kitchen and some office space. We found this area to be clinical in appearance and unwelcoming.

The nurses' station is in this area of the ward. This is an open area in the corridor which allows members of staff to observe ward activity from a distance, particularly in the adjacent bedroom area, and to respond promptly when needed. The treatment room and two offices are also accessed from this area and there are two bedrooms which have been converted into clinical space. We used the converted bedroom spaces to meet with people at the time of our visit and found them to be dark, stark and unwelcoming.

The bedroom area is at the far end of the ward with all bedrooms opening on to one small area of the corridor. Each person has their own small bedroom and en-suite area. At the time of our visit, we could see and hear people who were distressed and people who were having periods of time in seclusion in their bedroom. The bedroom area was noisy and as people had extra staff to support them at such times, it was also busy and cramped.

People can go out into the grounds of the hospital for walks and group activities. There is also an adjacent therapeutic garden space which can be accessed. We were told that the green space around the ward was frequently used by members of the public to walk their dogs and this reduced accessibility for people in Claythorn House. We could see how busy this area was at the time of our visit.

There is an enclosed garden area running along one side of the building, which people in the service can use, however, we were told that this was not sufficiently private from members of public, or secure as to be useful as an area that could be used when people were distressed and would value time outside.

One family member told us that the bedrooms were small and cold. They also spoke about there not being enough quiet space to do activities in.

Nursing staff told us that the physical environment in the ward means that they are “always losing” and said that “we do our best” but that the environment increased the use of restrictive interventions. Staff told us that the layout of the ward increases the risk of people clashing with each other and that the nursing team may have to restrict individuals to reduce the risk of aggression and retaliation from others.

Nursing staff told us that they were concerned that people may be secluded in their bedrooms when this should be a person’s safe space.

One of the multidisciplinary team spoke about the small bedrooms, the lack of sensory spaces and the lack of outdoor space. They told us that the ward environment is not conducive to therapeutic work and spoke about “doing the best with what we have”. We were told that the MDT were always “firefighting” and that there may be a reliance on seclusion because of the lack of space in the service.

Other members of the MDT told us that there is a need for therapeutic areas in which to meet with people for assessment and therapeutic activities. They also spoke of the need for quiet areas in the ward for staff, to give them time to think, to complete their paperwork and to have space for their breaks.

We heard from the occupational therapy team about a sensory audit of the ward that had been undertaken and some of the findings of that related to noise, lighting and triggers for distress. We were also told that one of the unused bedrooms would be adapted into a sensory area, with a plan that this work would begin in the next few weeks. We look forward to hearing about progress with this.

We heard from the head of service that the ward design no longer met the needs of the current patient population and impacted on their ability to provide the best possible care and support. We heard that service redesign is required and that there is current work underway to review the environment in the two adult inpatient learning disability services, Claythorn House and Blythswood House (currently in Munro Ward at Stobhill Hospital).

We found that the ward environment does not meet the developmental and sensory needs of the people in Claythorn House. We found the ward to be stark, clinical and unwelcoming with concerns about the layout, noise and lighting levels, lack of flexibility and lack of secure outdoor areas. There is a lack of suitable therapeutic space, insufficient office space for staff and a need for quiet areas for people and staff.

We saw people who were distressed being supported in the small and cramped bedroom areas adding to the distress and trauma experienced by all, increasing the risk of interpersonal violence and the use of restrictive interventions and further impacting the ability to support people to access the community and progress towards discharge.

Service redesign should continue to be a priority with the establishment of a model that supports people's recovery and progress towards community living. Factors to consider should include, but not be limited to, providing care and treatment in a homely and welcoming environment, the small size of the bedrooms, the need for people to have their own quiet areas away from others, and the availability of calm and quiet spaces in which people and staff can undertake vocational, therapeutic activities and clinical tasks.

We met with the service following our visit and heard that consideration had been given to the capacity of the service to accept further admissions at this time, in addition to maximum bed numbers, recognising the levels of acuity in the service and the impact of this on individuals. We support this approach and were pleased to hear about the reduced bed numbers and the intention to stop admissions wherever possible.

Recommendation 2:
The service manager and head of service must urgently review the provision of care and treatment in Claythorn House to ensure that the MDT can provide effective care and treatment to all individuals in the service. Consideration should be given to the capacity of the service to accept further admissions at this time, in addition to maximum bed numbers, recognising the levels of acuity in the service and the impact of this on individuals.

Recommendation 3:
The service manager, with support from the MDT, should review the provision of psychological support to individuals and staff who have been affected by the levels of violence and aggression in the service, including processes to support people following incidents including the use of restrictive interventions.

Recommendation 4:
The service manager should ensure that the current staffing model supports the therapeutic approach of the service and that staff have the necessary skills and training to provide consistent care and treatment to people with complex developmental needs.

Recommendation 5:
The head of service and service manager should urgently review the physical environment in Claythorn House to ensure that the service can meet the diverse needs of the people in the service and can support positive behaviour support approaches with the aim of reducing restrictive care practices.

Recommendation 6:
The head of service and service manager, with support from the health and social care partnership, estates and the health board, should continue to prioritise reviewing the physical environment in Claythorn House to ensure that the service model supports people's recovery and transition to community living.

Recommendation 7:
The head of service and service manager should urgently review the physical model in Claythorn House to ensure that it provides for the sensory needs of individuals in the service. This should include the levels of noise, appropriate lighting and the provision of sensory spaces and activities.

Recommendation 8:
The head of service and service manager should urgently review the physical model in Claythorn House to ensure that people in the service can access a safe outdoor space in which to engage in preferred vocational and sensory activities. This should be of sufficient size to give people who are distressed and agitated space to move freely around.

Any other comments

We escalated our concerns to senior staff, the service manager and head of service at the time of our visit and have had a further meeting to discuss their ongoing actions in relation to those concerns. The Commission will continue to monitor care and treatment in Claythorn House as a priority.

Summary of recommendations

Recommendation 1:
The senior charge nurse and service manager must ensure nursing supervision occurs at agreed intervals and undertake an audit of the same.

Recommendation 2:
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Service response to recommendations

The Commission requires a response to these recommendations within two 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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