Healthcare Improvement Scotland

mental welfare commission for scotland

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

Glasgow Royal Hospital for Children

National Child Psychiatry Inpatient Unit – Ward 4

NHS Greater Glasgow and Clyde

August 2025

Contents

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 the National Child Psychiatry Inpatient Unit. The unit is located in Ward 4 at the Glasgow Royal Hospital for Children. It provides flexible inpatient psychiatric services for children aged 5-11 years with severe psychiatric disorders, which may be complicated by neurodevelopmental disorders, physical health problems and complex psychosocial factors. Whilst Ward 4 is for children aged from five to 11 years, children over 11 may, on occasion be admitted if it is assessed more appropriate for them, for example, if they have a developmental delay. This is assessed on an individual basis. As the unit is a national service, referrals are received from all Scottish Health Boards.

About this visit/inspection

We undertook a joint unannounced visit/inspection to the National Child Psychiatry inpatient unit (which we will refer to as Ward 4) at the Glasgow Royal Hospital for Children on two days 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) scrutinized 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 Ward 4, the young people receiving care and treatment in Ward 4, 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 the National Child Psychiatry Inpatient unit (located in Ward 4 at the Glasgow Royal Hospital for Children) over a two-day period in August 2025. The six bedded unit was not full at the time of our visit.

The length of stay of the young people in Ward 4 ranged from around two weeks to a little over four months. Some of the young people were receiving care and treatment on a compulsory basis according to the Mental Health (Care and Treatment) (Scotland) Act 2003.

The health records of three 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.).

Two young people and three nursing staff who described themselves as the young people's key workers/named nurses engaged with us.

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

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

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

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 Ward 4 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:

During our visit we received feedback from the young people who were well enough to engage with us.

We heard from the young people that they had been given enough information about the ward/unit and were informed of their rights. This was said to be easy to understand, and we noted large font, pictorial formats being used based on the individual needs of one of the young people. Young people told us that they were informed about advocacy support and able to see their parent or carer when they wanted to.

Although three staff met with us and identified themselves as named nurses/keyworkers for the young people on the unit, the young people themselves did not seem to understand that they had an individual named nurse or keyworker. Young people instead spoke about staff as a 'collective' and talked about getting to know them and this taking time. They spoke about staff being 'nice' and 'helping' them to get better.

They said they feel listened to and are able to ask staff questions. Observation status was not described as obtrusive but instead opportunities to get to know staff better, chat and sometimes do extra activities. Healthcare Improvement Scotland talk more about observation status and continuous interventions later in this report.

The young people who spoke with us told us that they have a plan of what is going to happen to make them well so that they can leave the ward/unit and said they helped to make their plan.

Those young people who were prescribed medication told us that they understood why they needed it and were happy to take it.

Where there was experience of restraint, there was understanding of a 'safe hold' being used with helpful distraction techniques used. Although 'scary' we heard about feeling supported throughout and being asked how they felt afterwards. A post incident health check was also completed. A relative told us that they had agreed with the intervention which they described as proportionate given the risk to life. *"It is difficult for a parent to accept however, I was extremely confident in staff who were involved in the restraint that they would provide specialist support at this time".*

Those who engaged with us felt they were not discriminated or treated differently to others although one person wondered if they had been treated differently because they raised an issue about staff behaviour. They had been

reassured by their family that this was not the case.

No concerns were raised about the level of activities/access to education whilst on the ward/unit. Walks, café visits, art, and relaxation groups were mentioned and attendance at school two hours per day and occupational therapy support was particularly valued and enjoyed.

Young people said that they felt safe on the ward, and one said it was quiet enough to sleep at night in the ward.

None of the young people on the ward had completed an advance statement. There was a view from senior staff that this was not applicable to the age group of young people looked after in Ward 4. This is not the case; there is no upper or lower age limit regarding the right to have an advance statement.

The young people were asked to rate how well they thought they were looked after on the ward/unit overall. They said it was 'really good'.

"There have been some difficult times, but staff have helped me through these and my care plans have also helped as they make sure everyone knows what care I need".

Carers/Relatives

What we expect:

Section 278 of the Mental Health Act 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[2]

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:

The relatives of all the young people in the unit engaged with us during our visit to Ward 4.

We heard significant concerns in relation to involvement and impact of children's community mental health services including community psychology services. Relatives spoke of not feeling listened to, waiting more than 13 weeks for a response to a complaint. One of the mental health officers (social worker with specialist mental health training) was also concerned about the mental health act knowledge of nursing staff in community Child and Adolescent Mental Health services (CAMHS). As a result, families spoke of crisis points being reached prior to admission.

However, the admission process involving Ward 4 staff and the subsequent care, treatment and support provided in the inpatient unit was described in extremely positive terms by all relatives with no exceptions. *"I feel as if I am part of the MDT [multidisciplinary team] which is a good feeling".*

The relatives spoke of an inclusive approach where they felt centrally involved in care planning, felt able to express their views including if they had a different opinion, felt communication was clear and understandable and information was readily provided. Staff were described as *"kind, compassionate and approachable". "The team are very specialist and provide bespoke and individualised care and support".*

No concerns were raised regarding the level of activities with relatives telling us about mindfulness, sensory activities, access to the garden, outings in the community making connections, art therapy, occupational therapy, all of which were explained in terms of person-centred, bespoke approaches. One relative said they had been concerned about the activity that might be available in a clinical setting but told us they need not have worried.

An adult carer support plan had not been discussed with two of the relatives/carers and both said they would pick this up with their allocated social worker/mental health officer.

On a sliding scale of five points from 'very satisfied to dissatisfied', relatives described being 'very satisfied' with the care and treatment provided to their young person.

"I have full confidence and trust in staff. They are very knowledgeable and skilled at their job".

Staff working directly on the unit

What we expect:

The 2020 Child and Adolescent Mental Health Services (CAMHS): national service specification[3] 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 Ward 4 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 Ward 4. We are grateful to the eight staff who took time to speak with Commission visitors and/or completed the questionnaire provided.

All staff talked about enjoying their work, using their specialist skills and seeing young people getting better. Consistent themes from all staff included individualised care *"one size does not fit all"* and the team working which was highly valued and respected.

"The team challenge each other and invite each other to think outside the box".

"…a great team who are mindful of supporting each other."

Several staff were quick to acknowledge the resources available to provide high quality, intensive support and care in Ward 4.

"The resources and access to funding is amazing, which you just don't get anywhere else".

"We are able to spend a lot of time with the kids and their families getting to know them and developing a person-centred care plan".

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.

All staff reported that they understand the relevant consent and decision-making requirements of legislation and had completed child and adult

support and protection training. There was consistent reference back to the trusting, team dynamics in Ward 4 and the strength of such a cohesive team on the ward to ensure that practice is as good as it can be.

All bar none of the staff who engaged with us said they felt supported to do their differing jobs to the best of their abilities. Time to reflect, supervision and managerial support were noted to impact positively.

"The ward management team are excellent, so supportive and caring. They view staff as an asset which is important for staff morale".

All eight staff said they would have no hesitation in 'speaking up' if there were any concerns and it was explained that the culture fosters this.

When asked what gets in the way of giving the highest quality of care and treatment staff want to give to people, Ward 4 staff did not identify anything in particular *"can't think of anything".* One member of staff did reflect on lack of funding elsewhere which sometimes means that children and their parents come to the unit with poor experiences and a lack of trust in services. "*The team here work hard to repair and restore that trust*".

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[4]. Section 259 of the Act enshrines this in law.

We therefore expect that all patients are offered independent advocacy support and 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 which works with Ward 4 is not a specialist child advocacy service; a small number of advocacy staff with a special interest in this area provide all support to the ward. However, the advocacy service told us that they feel ward staff respect, value and encourage advocacy. They explained that they had some limited involvement with two patients on the ward during our visits (limited based on the choice of the young people).

The advocacy service described the ward as welcoming and accommodating. They told us that they run advocacy awareness groups during school breaks e.g. summer, Easter. This allows them to connect with young people in a group session as well as progress collective advocacy.

The advocacy service said they had no difficulty raising any concerns and made explicit reference to their professional responsibility to report anything they believe is child protection or an abuse of power as per local child protection guidelines.

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 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[5] and also monitors the provision of these statutory reports.

What we heard:

Two MHOs provided their views as part of this visit/inspection process. Both reported active involvement; one MHO had become involved two weeks previously and the other had been involved with the young person prior to admission and was critical of the community support that had been provided earlier.

Both MHOs had been invited to the multidisciplinary ward meetings and spoke positively about their experience of working in partnership on the ward. They said they found staff to be very professional and knowledgeable about the young people and referenced structured, cohesive care plans with *"no stone left unturned".*

"I have been very impressed with the professionalism and true multi- disciplinary

set up on Ward 4 providing a holistic service to the patient and family".

"*Working with the team in Ward 4 is a fantastic experience".*

Both MHOs told us that they are confident and competent in relation to their child protection/adult protection responsibilities with one in receipt of an extended professional qualification in child protection. Neither had any concerns in relation to the care provided on Ward 4.

A social circumstances report (SCR) should have been prepared for one young person, but this had not been done. The reason given for incompletion was *"work pressures and time restraints".* National standards for MHO services[6] are clear that MHOs require to fulfil their statutory duties 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.

The two MHOs currently actively working with young people on the ward spoke highly of the communication and quality of care and support provided in Ward 4. Both commented on the holistic[7] approach taken to working with the young person as a unique individual.

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 staff we spoke with across the range of disciplines took time to engage with us and spoke about what works well in Ward 4 with some remarking on feeling lucky to work here.

We learned a great deal from our Commission mental health nurses, mental health officers (social workers) and psychiatrists jointly reading the case records of all the young people in the unit and cross-referencing with incident records.

The records held on Ward 4 were all assessed as detailed and informative with evidence of inclusion of relatives and the young person where appropriate. The young person is invited to sign off their care plan if they wish to do so. There were 'child friendly' individualised aspects noted and where nasogastric tube feeding was required, a clear rationale and associated care plan informed by the dietician was evidenced.

Regular medical reviews, including physical health checks and multidisciplinary team reviews, were recorded as was discharge planning at the earliest opportunity based on individual needs. The level of multidisciplinary detail provided a high-level understanding of each of the young person's circumstances and goals for care, support and treatment.

The following are the key findings which emerged from what we heard, what we observed and what we read.

Key findings

General

The feedback we received from young people, their families, advocacy staff and mental health officers about the quality of care, treatment and individualised support provided on Ward 4 was overwhelmingly positive. Staff were praised for their inclusive approach, their specialist skills, and their knowledge, and the care delivered was described as "gold standard". One relative explained that her "standards are extremely high" but they were met on Ward 4.

The multidisciplinary staff team on Ward 4 described a committed, cohesive team and commented positively on their partnership working to do the best for the young people and their families. We learned about how this extended to innovative fundraising and charity work and one example of nursing staff raising £17k for the ward.

Staff spoke about feeling fortunate and supported, having enough time and resource to do the job to the best of their abilities whilst referring to other clinical areas where staff do not have this and are "burnt out".

Use of restraint/seclusion

The matter of restraint was not a significant issue highlighted during the visit to Ward 4.

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)[8] 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[9]. The National Safety Council suggest ideally having up to five people present to safely control a patient[10].

Where we were told about restraint, we heard that this was proportionate, supportive and noted that it was in keeping with our good practice guidance, Rights Risks and Limits to Freedom. We found no restraint related concerns in the records of the young people on the ward.

Healthcare Improvement Scotland reviewed data of incidents on Ward 4 for the six months prior to our joint visit and report in more detail on the process of reporting and data later on in this report.

The use of seclusion was not part of the care of the young people we met during our visit. However, there is a seclusion room on Ward 4, and this has previously been assessed as not fit for this purpose. And while there is a policy in place based on the Commission's good practice guidance 'The Use of Seclusion', there is not a health board wide policy.

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, nasogastric tube (NGT) feeding and electroconvulsive therapy (ECT) may be lawfully authorised. Part 16 of the 2003 Mental Health Act[11] 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.

The Commission found no concerns in relation to lawful authority to treat the young people on Ward 4. We did, however, note concern about the authority to treat with medication immediately prior to admission to hospital for one young person and will follow this up with the service.

We were able to see a copy of a sample audit undertaken in June 2025-July 2025, the outcome of which confirmed that 100% of cases had correct, valid documentation (T2 and T3 forms). The Commission welcomes the intention to undertake these audits regularly and the recognition that this is vital for

the safety of the children and young people in the ward.

An important aspect of ensuring that an individual's treatment is lawfully authorised relates not just to authority for treatment being obtained but also ensuring that it is exercised. We would expect that copies of treatment forms are available to support nurses when they dispense treatment to individuals on the ward, acting as a reference point to ensure the treatment that an individual is receiving is lawfully authorised. We were able to locate treatment forms where they were required, stored electronically with the prescription patient information system (HEPMA). We had made a recommendation to this effect on our last visit to Ward 4 and would view this addition to be best practice, as the authority for treatment is now easily verifiable for anyone prescribing medication or dispensing medication.

Care planning and family involvement

There was generally high-quality recording, detailed care plans which evidenced the views of the multidisciplinary team, the young person and their family member (talking mats training had been delivered across the staff group). Each care record had the original care plans which were then combined and converted to a 'child friendly' version, dependent on the age and development stage of the young person, using pictures and symbols as appropriate.

The 'two stars and a wish' feedback mechanism is carried out with young people prior to discharge from Ward 4. This involved feedback on two things they liked and one thing that could have gone better. A simple concept, perhaps, but very effective and evidenced a commitment to capture views. This is discussed further later in this report.

Activity / Education

No one we spoke with raised any concerns about the level of activity or opportunities on the ward. Indeed, there was evidence of a ward activity board with each young person having their own personalised planner in their bedroom which was updated every evening. We noted nurse led groups looking at life skills, relaxation, decider skills, social skills etc. Occupational therapists and speech and language therapist teams provided specialist expertise and there were a range of arts and crafts groups, film making groups, a sensory room, cinema, hydrotherapy pool, outings to the local area, a summer programme and more. All activities were tailored to the age, stage and interest of the individual young person.

Findings requiring action

A previous Quality Network for Inpatient CAMHS (QNIC)[12] report found the seclusion room to be not fit for purpose due to no window and no clock. There are also no toilet facilities. Action needs to be taken, and a requirement has therefore been made at the end of this report to ensure this.

Whilst there is local guidance in place, based on the Commission's good practice guidance on seclusion, an NHS Greater Glasgow and Clyde seclusion policy needs to be in place to underpin the use of the seclusion room. A recommendation is therefore made at the end of this report.

We found no promotion of advance statements (section 275 of the mental health act) and understood this related to a view that advance statements do not apply to the age group of the young people admitted to Ward 4. Our guidance[13] is clear that there is no upper or lower age limit. Anyone has a right to make an advance statement, and we recommend that Ward 4 build the offer of an advance statement into practice when the person is well, as part of discharge planning.

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

As stated previously, Ward 4 is the national Tier 4 specialist service for children who require assessment and treatment for severe and complex mental health needs which may also be complicated by neurodevelopment disorders, physical health problems and psychosocial factors. Neurodevelopment disorders are a group of conditions that can lead to difficulties with cognitive, emotional, social and physical functioning. Neurodevelopmental disorders include autism spectrum disorder, attention deficit

hyperactivity disorder, communication disorder and intellectual disability. Referrals to the ward are accepted from Tier 3, Tier 4 and learning disability Child and Adolescent Mental Health Services teams from across Scotland. For further information on Child and Adolescent Mental Health services specifications please see here.

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 on admission to Ward 4 during our onsite inspection.

Evidence provided includes NHS Greater Glasgow and Clyde Specialist Children's Services Ward 4 CIPU Admission to Discharge Pathway. This discusses pre and post inpatient outreach support such as, a young person attending the ward as a day case prior to the need for admission or as part of transition to discharge. The National Child Inpatient Psychiatric Service Annual Report 2024/2025 describes the use of outreach care plans to support discharge when a young person is able to be discharged from the ward but their family or local services require specific input from the ward**.** Senior managers also advised that the outreach service can provide support to families and young people prior to admission.

Staff advised that additional beds are not utilised on Ward 4. An additional bed is a temporary bed that is added to increase capacity during periods of high demand. However, we were advised that a pass bed could be used for an admission if required but that this was not common. A pass is when a young person has planned leave from the ward such as during weekend home leave.

Ward 4 is a six bedded unit that is comprised of three single rooms and two double bedrooms. However, only one double room is considered for shared use with the remaining double room remaining single occupancy. We spoke with staff regarding the use of double rooms who advised that the ward usually ran at approximately 85% capacity and that the double rooms were very seldom used. As noted previously, the ward was not full during our onsite visit. The double rooms will be discussed further later in this report.

We observed that the ward environment was bright, airy and uncluttered. There is a dining room, classroom, lounge and games area, soft play area, sensory room, music room and a rooftop garden. There are also a number of visiting/consultation rooms to enable privacy. We also observed quiet areas utilised throughout the corridors, including reading corners and jigsaw areas. There was artwork which had been completed by young people displayed throughout the ward and a "pet wall" which was a poster with pictures of young peoples and staff pets.

The Hospital Education Service provides education for children and young people who are admitted to the Glasgow Royal Hospital for Children. We were provided with the Ward 4 information pack for parents and carers as evidence. This

documents that the ward has teachers who are based within the ward who provide education, as well as assessing young people's academic abilities and needs. The teaching staff can provide secondary as well as primary level education for children who are transitioning to secondary education. The welcome pack also highlights that teaching staff will liaise with the child's base school to ensure where able, that work will link with the young person's current curriculum.

The Ward 4 information pack for parents and carers includes information such as ward contacts, description of who is in the ward team, daily ward routine, family support and therapy, complaints procedure and information on advocacy services including how to contact them. 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. We observed that there were posters in the main corridor of the ward which included information relating to advocacy services and how to contact them. We can also see in evidence provided that every young person is offered advocacy services. As part of our joint visit the Mental Welfare Commission were able to speak with advocacy staff as noted earlier in this report.

There are a number of posters on the wall in the main corridor of the ward which include QR codes which, when scanned, open a link for a number of detailed online information resources. These include Anorexia Parent/Carer Resources, Autism Parent/Carer Resources, Detention and the Mental health Act and Support for Parents/Carers When Your Child Is in Ward 4. The support for parents and carers resource includes a copy of the ward welcome pack and also links to various resources for general and financial support whilst their child is in hospital. We also observed an available QR code and poster for "Developing Dolphins 2". Developing Dolphins 2 is provided by 'Beat' eating disorders charity and is a free online training course for carers of someone over the age of 10 with an eating disorder. Beat is a nationwide organisation that provides support to people affected by eating disorders, their friends and families.

Accessible information for children is the provision of information that is in a format that is easy to understand. This can include the use of pictures, short sentences and easy words. Evidence provided includes the Ward 4 Children's information pack for younger children. This includes short explanations of the multidisciplinary team and uses less text and more pictures. There is also an available Ward 4 information pack which is predominantly pictures and symbols with minimum text.

Ward 4 has flexible visiting times and electronic tablets and phones are available for young people to contact their families as they may have to travel long distances to visit. Senior managers advised that there are no dedicated overnight accommodation facilities for families within the unit. However, we were advised that staff can support families in making arrangements for accommodation. The Young Patients Family Fund at the Glasgow Royal Hospital for Children can also provide financial support for travel, food and accommodation for families who are visiting a young person in the hospital. Senior managers also advised that, if appropriate, young people and families can access Crossbasket House. This provides an additional space for family visits out with the ward environment. Crossbasket House has a library, three quiet lounges and a garden. Crossbasket House is based within the Glasgow Royal Hospital for Children campus and provides a homely environment for families away from the hospital environment.

Evidence provided includes NHS Greater Glasgow and Clyde Specialists Children's Services Ward 4 Patient and Family Support document. This describes the processes in place to enable children and their families/carers to provide feedback to incorporate their views on service delivery and to improve outcomes and experience of care. The document describes that prior to admission there will be an 'early care planning meeting'. This involves meeting with families and the care team to identify goals and consider factors in developing the young person's care plan. Meetings of this group are held every four to five weeks to review progress and enable families/carers to be part of decision making. If children do not wish to attend these meetings, they are encouraged to provide staff with any questions or feedback they may have. Feedback from the meeting will then be provided to the young person by the nursing staff. We can see in evidence provided that a parent and carer support group is being developed. During our virtual discussion with senior managers in November we were advised that the support groups have now started with scheduled dates for the next six months in place. The sessions are facilitated by staff who have experience in family engagement and feedback will be obtained to see if meetings are beneficial and are meeting the needs of the families.

All children and their families are offered the support of the Ward 4 care manager whose role is to coordinate the young person's care. This includes liaising with their community Child and Adolescent Mental Health Services team, social worker and school. Families and carers will be offered weekly meetings with the care manager to enable them to have the opportunity to be provided with updates about their child's progress and care and ask any questions or provide feedback. Staff spoke highly of the care manager role. We can see in evidence provided that Ward 4 also has a family and systemic psychotherapist who works with and supports young people and their families during their admission.

Each young person's care is reviewed and discussed at weekly meetings which include all members of the multidisciplinary team. This includes, but is not exhaustive of, nursing staff, psychiatry and psychology and care manager. Senior managers advised that young people and their families do not attend these meetings. However, they are provided with a form that can be submitted with any questions or suggestions and feedback is then provided to them by the staff. Both the family/carers and young person's form include an area for any updates or feedback from the family and any questions they would like raised at the meeting. Updates from the meeting is recorded by staff on the forms which are then returned to the young person and their families. We did not have the opportunity to speak with any families or carers of young people during our onsite visit. However, as is noted earlier in this report the Commission were able to speak with a number of families.

We asked senior managers to provide us with a breakdown of any complaints received in the past 12 months; they advised that there had been no formal complaints submitted over the past year relating to Ward 4. However, we were also advised that lessons learned from informal feedback are shared with staff, including at the nurses' meetings, the minutes of which are also shared via email.

NHS Greater Glasgow and Clyde utilise "Experience of Service Questionnaires". These enable young people and their families and carers to provide anonymous feedback. We were provided with submitted responses for the 12 months from August 2024 to 2025. During this time only five responses were submitted, one of which was completed by a young person. We can see from these that the majority of comments were very positive including in relation to communication, support, understanding and ensuring person centred care. There were, however, two comments relating to the use of supplementary staffing. Supplementary staffing will be discussed later in this report. We asked senior managers how feedback from the questionnaires is shared with staff who advised that results are collated and included in the annual report. We were also advised that these can be discussed at

the nurses' meetings and operational management group.

The Ward 4 carers/parents information booklet includes detailed information on how to provide feedback or raise a complaint. This includes discussing with the nursing team, care manager or ward manager. It also details that the Citizens Advice Scotland provide an Independent Advice and Support Service (IASS), which can provide confidential and impartial advice. The booklet also highlights that the NHS Greater Glasgow and Clyde Family Support and Information Service can also be contacted for support.

Inspectors and the Commission observed the “two stars and a wish” board in the main corridor of the ward. This is completed by young people prior to discharge and provides them with the opportunity to highlight two positive aspects of their experience and also an area they would like to change or improve. Stars we observed included positive comments regarding staff and the provision of varied activities. Feedback demonstrated through the wish board included wishing school was easier and wanting more staff. We were advised that the “you said we did” board would be utilised to provide feedback regarding changes that had been implemented. We observed the board during our inspection which included feedback relating to food and the purchase of new chairs for the outdoor area.

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 child and adult support and protection which shows that 100% of staff across the Ward 4 multidisciplinary team have completed public protection training. Senior managers confirmed that this includes both adult and child protection.

We asked senior managers what processes are in place for the review and oversight of any public protection concerns on Ward 4. We were advised these include escalation to the nurse in charge of the shift who will then contact NHS Greater Glasgow and Clyde public protection team, child protection lead or social work team. A notification of concern will be completed if assessed as appropriate. 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. All actions will be recorded on the young person's electronic care records. Senior managers advised oversight of this sits with NHS Greater Glasgow and Clyde Public Protection forum. This monitors compliance, reviews incidents and ensures staff training. There is a representative from Specialist Children's Services on the forum. Clinical oversight and care of the young person remains with the clinical team at Ward 4 and any required additional support will be escalated to the service manager and clinical director.

We were also advised that senior managers from Ward 4 attend the NHS Greater Glasgow and Clyde Specialist Children's Services Quarterly Public Protection Interface Group. This group is attended by senior managers and members of the child protection team and discusses child and public protection items as part of the standing agenda.

Ward 4 nurse staff meetings are held weekly and include standing agenda items such as staffing, matters arising, health and safety/infection control/audits and training. The meetings also start with the opportunity for staff to share “what’s going well and not so well”. We can see it is documented in one of August 2025 meetings that there was discussion relating to child protection including staff ensuring they have completed their training and are aware of roles and responsibilities. We asked senior managers how the minutes of the staff meetings are shared with staff who advised they are e-mailed to staff and copies saved on an electronic platform that are accessible to all staff.

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 the ward. We can see from this that 96% of staff across the multidisciplinary team have completed fire safety training, including 97% of nursing staff. Evidence provided includes the fire action plan for Ward 4 which is in date and not due for review until August 2026. This includes a breakdown of actions to be taken in the event of a suspected or actual fire including evacuation.

The 2025 annual NHS Scotland Firecode Fire Risk Assessment and associated action plan for the Glasgow Royal Hospital for Children highlighted areas for improvement throughout the site. This includes replacement, repair and maintenance of fire doors. The fire risk assessment documents that approximately 22% of the fire doors at the hospital require some form of remedial action. Deficiencies noted include damaged door frames and fixings, damaged hinges and damaged smoke seals. It is also noted that the existing door surrounds and fixings are not suitable to sustain the general wear and tear of a busy hospital environment.

Senior managers advised that there is an ongoing programme to replace defective fire doors across both the Queen Elizabeth University Hospital and Royal Hospital for Children. This is to ensure effective fire compartmentalisation throughout the hospital. Survey and assessment of fire doors is ongoing with priority being to replace those in the worse condition. Senior charge nurses also conduct monthly Fire Safety Audits. We were provided with the two most recent audits for Ward 4. The audit template includes questions specifically relating to fire doors with a prompt to notify the Estates helpdesk if any issues are identified and includes a section to document reference number of report and date reported. Both monthly fire safety audits for Ward 4 have been completed fully and no concerns are

highlighted including in relation to fire doors. The monthly fire safety audits are submitted via email, any identified areas for attention will be escalated via telephone call which is then followed up by email. Senior managers advised that Ward 4 does not have any current outstanding actions from the fire risk assessment.

Whilst we recognise ongoing oversight and improvements 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 and the Commission spoke with described a supportive and visible team at ward level where they feel supported to raise concerns. Senior managers advised of a recent increase in the multidisciplinary team establishment including, psychology, occupational therapy, speech and language therapy and family therapy. There was also an increase of six band five registered nurses, three band six charge nurses and two health care support workers.

Nursing staff we spoke with described adequate staffing levels with the aim of having one of the band six charge nurses on all shifts to provide leadership and support. We were able to speak with a number of student nurses, all of whom were very positive about their placement on the ward including the support provided. As part of our joint visit, the Mental Welfare Commission spoke with members of the wider multidisciplinary team including medical staff as noted earlier in this report.

The multidisciplinary team for Ward 4 includes nursing staff, psychiatric medical staff and paediatric medical staff. The team also includes psychology staff, art, music and family therapists and allied health professionals. The allied health professional team includes physiotherapy, pharmacy, occupational therapy, dietetics and speech and language therapy. The nursing staff establishment includes health care support workers and both mental health and learning disability registered nurses. Nursing staff work a 12-hour shift pattern with eight nursing staff on the day shift and four nursing staff on the night shift. The day shift is aimed to comprise of 70% registered and 30% health care support workers with night shifts 50% of each. Staff told inspectors that there is a 15 minute handover at shift change over and a clinical pause at 4pm to update and discuss any actions from the day. There is an extended handover on Mondays between the medical and nursing staff and where able, the multidisciplinary team to update from the weekend. We were able to attend the morning handover during our onsite inspection. This was patient centred with each young person's care discussed including if their care plans needed updating. There was good representation of the multidisciplinary

team including nursing and medical staff and allied health professionals.

The Ward 4 Role of the Nurse in Charge/Shift Coordinator document explains that it is the responsibility of the nurse in charge/shift coordinator to ensure all ward duties and tasks are completed. These include ensuring managing staff breaks, ensuring efficient workflow and patient care and completion and documentation of regular safety checks. Ward 4 utilises a 15 minute checklist sheet. This enables documentation of where all young people are within the unit at 15 minute intervals. It also has areas to confirm environmental checks such as ensuring if any ligature risks are removed and doors that do not need to remain open are locked. There are also checklists for ensuring the ward environment is clean and uncluttered. During our onsite inspection we observed that staff were completing these checks including completing the documentation.

Senior managers advised us of a recent increase in the multidisciplinary team establishment with additional funding being approved in April 2024 to support safe staffing levels to meet increased acuity and dependency. It is documented in the National Child Inpatient Psychiatric Service Annual Report 2024/2025, recruitment into the additional posts is almost complete. During our virtual discussion with senior managers on 26 November we were advised that all posts have now been successfully recruited to and the ward does not have any current vacancies. It is also highlighted in the annual report that the multidisciplinary team is now fully established and has been developed to ensure a depth of knowledge and skills across the service. This includes the physiotherapy post that was a test of change being made permanent with increased hours, in addition to the recruitment of registered learning disability nurses.

During our onsite inspection staff told us of an increase in violence and aggression toward staff by young people over the past 12 months, some of which had resulted in injuries to staff. 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. We can see that of the 496 reported incidents in the six months prior to this inspection that approximately 56% relate to violence and aggression towards staff by young people, with this being the second most reported category. 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.

The National Child Inpatient Psychiatric Service Annual Report 2024/2025 includes a breakdown of submitted incident reports for the 12 month period from April 1 2024 – March 31 2025. This documents that there has been a marked increase of 184% in reported incidents over this timeframe with the highest increase being reported incidents of violence and aggression. This has resulted in an increase in acuity and dependency, the use of supplementary staff, utilisation of continuous

interventions, the use of safe holds and an increase in staff sickness absence. Continuous interventions and safe holds will be discussed in more detail later in this report. We recognise that a rise in reported incidents may be attributed to the acuity and dependency of the young people on the unit at the time. Evidence provided includes a breakdown of reported incidents for the three months prior to our inspection. We can see from this that there has been a reduction in reported incidents including those of violence and aggression for the months of June and July. Personal alarms are available for staff who work on Ward 4 to summon help quickly in an emergency. We did not see any reported incidents relating to faults or lack of available alarms.

We asked senior managers what support and health and wellbeing initiatives are in place for staff who have been involved in episodes of violence and aggression. We were advised that senior managers had contacted health and wellbeing services and human resources to ensure available resources are in place to support staff. This includes availability of occupational health, debrief sessions and additional communication training. We were also advised that the NHS Greater Glasgow and Clyde safe care team had provided support and advice to the Ward 4 team. The safe care team is discussed later in this report.

We were provided with the Ward 4 Staff Health & Wellbeing Policy which highlights wellbeing resources that are available to staff including clinical supervision, peer support network, ward tuck shop and NHS Greater Glasgow and Clyde Spiritual Care Service. Senior managers also told us of the Ward 4 Staff Wellbeing Working Group. This is a short life working group which includes a core team of staff from all multidisciplinary team disciplines which has met four times so far. As a result of the meetings a staff wellbeing questionnaire is being piloted with the aim of identifying areas for improvement. The results of this will be actioned to improve staff wellbeing. A goal for the next 12 months includes refurbishment of the staff room to improve functionality, promote wellbeing and encourage informal peer support.

Senior managers told us that incident reports relating to violence and aggression are discussed at the East Dunbartonshire Health and Safety Committee. The NHS Greater Glasgow and Clyde health and safety practitioners can also provide advice. The multidisciplinary team will also review the young person's care plan to see if any changes need to be implemented.

We also saw a small number of incidents where staff had to intervene to prevent young people from assaulting student nurses. Senior managers advised that in these instances they would contact the practice education facilitator for the student to inform them of the incident and the student would be supported by the Ward 4 staff.

NHS Greater Glasgow and Clyde Staff Support and Wellbeing web page includes a number of health and wellbeing initiatives. These include self-referral to occupational health for counselling services, financial advice and a speak-up service. The speak-up service enables staff to confidentially raise concerns about patient safety and work conditions. The wellbeing page 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 reviewing post risk assessment.

Staff told us of the availability of debriefs following incidents, and regular reflective practice sessions facilitated by the psychology team which the whole multidisciplinary team can attend. We can see it is documented in the minutes of the nursing staff team meeting on August 21 that reflective practice is run every 4 to 6 weeks and new dates were due to be circulated. We asked senior managers if they had received any feedback from staff relating to reflective practice who advised that feedback had been positive and they were aiming to run sessions more frequently. We can also see that post admission team reflections are discussed in the team meeting minutes. These are debriefs following a young person's discharge, it is also highlighted that they can be done individually or in groups and that staff had found them helpful. Senior managers also advised that hot debriefs can be utilised and are again facilitated by the psychology team. A hot debrief describes an immediate debrief after an event to promote learning and reflection for those involved.

Staff also told us they are supported to attend clinical supervision sessions. However, we were not advised of how often these take place. 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.

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 100% of staff including nursing, allied health professionals and medical staff have completed prevention and management of violence and aggression training. It is also documented in evidence provided that safe hold training is a requirement to work within mental health areas within NHS Greater Glasgow and Clyde, including for supplementary staff.

NHS Greater Glasgow and Clyde safe care team provide 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 plans. 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. Staff also told us that the safe care team will provide support and advice if required and that there is a member of the Ward 4 nursing team who is a managing violence and aggression trainer.

The NHS iMatter survey is a staff experience tool which is completed yearly to enable staff, teams and health boards to 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 the organisation. Evidence submitted includes the 2025 iMatter survey results for Ward 4. We can see from this that 71% of staff completed the survey. This has an overall Employee Engagement Index Score of 85 which is higher than the score for NHS Greater Glasgow and Clyde as a whole which is 76. The employee engagement index score is calculated based on responses from strongly agree to disagree on a number of questions relating to staff members' experience. iMatter action plans are developed by teams to address areas of improvement highlighted in the iMatter survey. We can see in the Ward 4 action plan that desired outcomes include the team continuing to feel cohesive and for staff to feel included in decision making. Documented actions include arranging a team away day and staff attendance at the operational management group meeting.

We were provided with sickness absence data for Ward 4 up until July 2025. This shows that nursing sickness has continuously reduced from April and was 4.6% in July of which none was long term sickness. Long term sickness is defined as a period that lasts longer than 29 days. We can see that sickness absence is higher in July for other members of the multidisciplinary team. We asked senior managers how sickness absence is covered for the multidisciplinary team who advised cross cover is provided by NHS Greater Glasgow and Clyde Tier 4 Child and Adolescent Mental Health Services including paediatric liaison psychiatry and allied health professional teams.

We asked senior managers what support is provided for staff during sickness absence who explained that NHS Glasgow and Clyde Attendance Management Policy promotes early engagement and can provide phased return, reasonable adjustments and individual return to work plans to support staff to return to work. Staff have access to physiotherapy, counselling, stress management and peer support networks. Human resources guidance and toolkits are available for line managers to enable them to support staff during sickness absence.

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. As previously discussed, we were provided with the Experience of Service Questionnaire report for Ward 4 for the 12 months from August 2024 – August 2025. Whilst the majority of feedback was very positive, we did see two pieces of feedback regarding the use of supplementary staff and concerns relating to its impact on continuity of care.

During our onsite inspection senior managers advised that the use of supplementary staff has reduced following successful recruitment and that they have regular bank staff who are familiar with the ward. We were also advised that agency staff are not utilised. Nursing staff we spoke with confirmed this and told inspectors that they have a cohort of regular bank staff who are familiar with the ward. Evidence provided includes supplementary staffing use for the six months prior to this inspection. We can see from this that there has been continued use of both band 5 registered bank staff and health care support workers with an increase between January and March, May and July 2025. We discussed this with senior managers who advised this was in the main due to an increase in acuity and dependency on the ward during these months. This included an increase in the implementation of continuous interventions to maintain staff and young people's safety. There were no supplementary staff on shift during the days of our onsite inspection.

We asked senior managers what processes are in place to support and provide induction for supplementary staff and were provided with NHS Greater Glasgow and Clyde's Nursing & Midwifery Bank Orientation Logbook for registered nurses and midwives. This 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 Nurse Bank Health Care Support Worker Induction Learning and Resource Document includes role specific learning, including a general orientation checklist, continuous intervention policy and violence and aggression training. We were also provided with a blank copy of the NHS Greater Glasgow and Clyde Temporary Worker Checklist form. This documents that the checklist should be completed by the nurse in charge prior to supplementary staff commencing their shift. The checklist includes a number of questions including orientation to the ward layout, receiving a handover report for patients they will be caring for and that the temporary worker confirms they have the appropriate skills/knowledge to undertake their allocated duties.

During our onsite inspection staff told inspectors there was a clear process for escalating any concerns regarding staffing and that they feel supported and confident to do so.

Evidence provided includes a flow chart for staff to follow in the event of staff absence. This includes assessing whether acuity and dependency can be met with available staff and if not, steps to follow such as contacting other areas for assistance and contacting regular staff to see if they can cover. It is documented that if unable to cover the shift and assessed as being unable to meet acuity and dependency, this should be escalated to senior managers and the hospital coordinator for support. It is also highlighted that an incident form should be completed. Since our onsite inspection NHS Greater Glasgow and Clyde have implemented an electronic real-time staffing tool including on Ward 4. This enables staff to record live time acuity and dependency on the ward. We can only see two incident reports relating to staffing levels in the incident reports submitted in the six months prior to this inspection.

One of the two reported staffing incidents was due to an error in recording the nursing rota which resulted in the shift being one member of staff short. It is documented in the incident report that this was escalated to the on-call manager and an additional member of staff was provided to cover the shortfall. We cannot see it documented that the incident resulted in any harm to young people. The second incident involved increased acuity and dependency which resulted in a young person's mealtime support being stopped for a short period. It is documented that this was discussed with the young person and their family were notified. Mealtime support will be discussed later in this report.

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. Staff told us that two newly registered nurses would be starting employment on the ward in September 2025. We were provided with the Ward 4 induction pack which includes checklists for local orientation, policies and procedures and role specific learning including face to face learning such as safeholds and nutrition via nasogastric tube and safe holds. Nutrition via nasogastric tube and safe holds will be discussed later in this report. The induction pack documents that the induction period should take a minimum of four weeks and be completed within three months. Each new member of staff will be allocated a supervisor to work closely with and there will be a six and 12 week review. The induction pack also highlights support is available via the NHS Greater Glasgow and Clyde induction portal.

Staff told us of the Specialist Children's Services academic teaching programme as part of continuing professional development. 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,

introduction to family therapy and systematic practice, mental health and the role of the occupational therapist, and meal support for those with eating disorders.

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 the senior charge nurse for the ward advised us that they were provided with adequate time to lead.

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 Ward 4 demonstrate that all nursing staff have had an appraisal within the 12 months prior to our onsite inspection.

As previously discussed, NHS Greater Glasgow and Clyde is in the process of implementing an electronic real time staffing tool. This 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 2025. This training is 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.

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 reviews. 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 were no significant adverse events reported for Ward 4 in the past 12 months.

We were provided with an overview of the process in place in Ward 4 for the reporting and review of incidents. This documents that any adverse events or near misses should be reported within 24 hours with the timeline for reviewing, confirming severity level and identifying any further review to be within one week. 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 an automatic alert is sent to the relevant managers and governance teams when a new incident report is submitted. We were also advised that the governance teams monitor unallocated incidents daily to prevent delays. A monthly report of incidents and trends is presented at the Specialist Children's Operational Management Group monthly meeting. Learning from incident reports are added to the Clinical Risk Group and Operational Management Group meetings for sharing with staff.

We asked senior managers how lessons learned and themes from reported incidents were shared with staff who advised these will be shared at the nurses' meetings, the operational management group and with individual staff when required. The electronic incident reporting system has a number of approval stages including being in the holding area awaiting review, being reviewed awaiting final approval and finally approved. We can see that all of the incident reports submitted as evidence have been reviewed and finally approved.

Pathways, procedures and policies

We observed positive, compassionate and respectful interactions between staff and young people. The ward was calm and organised with staff we spoke with appearing to have a good understanding of young people and their family's needs.

We were able to speak with one young person who told us they feel comfortable speaking with staff and feel listened to. However, they did tell us that some staff had been using their phones during continuous interventions or mealtimes. We raised this with senior managers at the time of our onsite inspection who advised that this had been discussed with staff including raising at the weekly nurses' meetings. Staff had also been reminded that if they wish to use phones for such things as playing music for young people that the ward phones and electronic tablets should be used. In line with their methodology the Commission also spoke with young people as noted earlier in this report.

Staff told us of a number of quality improvement initiatives including the use of web based tools to enable creation, printing and sharing of resources through the

use of symbols to provide more accessible information. We observed examples of these in the information displays throughout the ward. Evidence provided also describes Lego based therapy which young people refer to as “brick club”. This is described as creating a meaningful, positive experience for children and young people by creating a safe, accepting environment to build confidence, social and emotional skills and friendship. Evidence provided also includes information on the “Skills Sharing Network” a group facilitated by Ward 4. The Skills Sharing Network enables the sharing of knowledge, skills and experiences from members of the multidisciplinary team who work with younger children in the field of mental health. Topics have included catatonia with learning disabilities and bipolar affective disorder.

During our onsite inspection staff told us about the use of “talking mats” which are a visual framework to support young people with communication difficulties to express themselves with the use of visual symbols. Evidence provided includes the results of a project which was undertaken to evaluate the impact of the talking mats. This documents that over a two month period, 14 members of the multidisciplinary team were trained to use talking mats. This included nursing staff, occupational therapy, speech and language therapy and psychology staff. At the end of this period two focus groups were undertaken and a survey was sent to the clinicians involved in the use of the mats to provide feedback. Of the 88% of respondents who reported using the talking mats all highlighted that it had a positive impact on care to build rapport, set goals and support young people to express their views. We discussed this at our virtual discussion with senior managers who advised that due to the success of the mats additional training will be provided.

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. Ward 4 has an activities coordinator from Monday to Thursday and occupational therapy provision from Monday to Friday. Out with these hours the nursing staff provide therapeutic activities. Senior managers advised that the nursing staff facilitate group programmes including life skills, social skills, relaxation and decider skills. Decider skills are a set of skills designed to help young people manage difficult emotions and/or impulsive behaviour such as self-harm.

Senior managers also advised that a member of staff had undertaken a formal qualification in play therapy. Play therapy is a specialised therapeutic intervention which uses play as a way of helping children understand and express their thoughts.

During our onsite inspection staff told us that the activity coordinator develops individual activity programmes for each young person. These are printed off and a copy provided for the young person in their bedroom and updated each night. We

were also advised that if assessed as safe to do so, young people can utilise activities that are available at the hospital such as the cinema, chaplaincy service and hydrotherapy pool. We were told by one young person that the hydrotherapy pool was out of use. We discussed this with senior managers who advised this was due to a fault and was in the process of being repaired, however, they had not been provided with a timeline for this.

Occupational therapy staff run a number of group or individual activities and complete an interests checklist for each young person on admission. We observed a poster in the ward highlighting activities the occupational therapy team provide, these include a sewing group, arts and crafts and therapy kitchen sessions. We were also advised that a summer activities timetable is developed to cover the school holidays. One young person did highlight to us there was less to do at weekends. As noted earlier in this report there were no concerns raised with the Commission by young people or families relating to activity provision.

Staff told inspectors of the weekly Ward 4 community group meetings during which activities can be discussed. The Ward 4 Patient and Family Support Policy describes that this is held weekly by the young people and facilitated by the nursing team. Young people can invite other people to the meeting such as chaplaincy and education staff to consider ways to enhance their experience on the ward. Staff also distribute a ward weekly newsletter to families and young people about updates on the ward such as highlighting current events or news. Senior managers advised that different types of arts and crafts equipment had been purchased based on feedback from the meeting.

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 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 62% of the submitted incident reports in the six months prior to this inspection relate to the use of safe holds. 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. Artificial nutrition via nasogastric tube will be discussed later in this report. It is documented in a number of the incident reports that de-escalation techniques had been attempted prior to using safe hold. These include verbal de-escalation, playing music and low stimulus environments. During our onsite inspection staff told us an incident form will be

completed if a safe hold is used and will also be recorded on the 'significant event' template on the young person's electronic care records. Documentation will be discussed later in this report.

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 one percent of incident reports submitted as evidence relate to the young person being placed in the prone position for safe holds. We can see that the majority of these were due to stress and distress including violence and aggression towards staff. The 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 breathing of the person who is in the safe hold must be uninhibited. Senior managers advised that all staff are trained in the use of face down safeholds as part of their mandatory safehold training.

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.

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 wide policy and 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 specific policy which is currently under review.

We asked senior managers what procedures are in place for the oversight of policies and procedures who advised that the specialist children's services Clinical Governance Group are currently reviewing policies for the National Child Psychiatric Inpatient Unit. We were also advised that adult mental health services have an allocated senior manager for policy reviews and the 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.

Evidence provided includes the NHS Greater Glasgow and Clyde Management of Acutely Disturbed or Challenging behaviour for Children aged 5 – 12 years (RHC) and Young People with Intellectual Disability policy. This highlights that fast acting sedation for the management of acute stress and distress should only be administered after appropriate de-escalation techniques have been unsuccessful and that oral medication should be offered first. It also documents that if oral medication is unsuccessful or refused and the young person is placing themselves or others at risk, that intramuscular medication should be considered. Within the incident reports submitted six months prior to our inspection approximately three percent record the administration of intramuscular sedation for reasons including stress and distress, violence and aggression and to administer treatment. The pathway documents the mandatory physical observations and monitoring to be undertaken after the administration of intramuscular sedation. This includes heart rate, respiratory rate, oxygen saturation and alertness. It was not clear in submitted incident reports if physical observations were carried out post administration. We asked senior managers if these would be recorded elsewhere and what mitigations would be put in place if young people declined to have observations recorded. We were advised that in these instances young people would have continuous interventions in place and staff would observe for any changes in respiratory rate or conscious level. Once the young person is more settled staff would record the young person's observations if able. We were also advised that physical observations are recorded on the young person's Paediatric Early Warning Chart. The Paediatric Early Warning Score (PEWS) is a system that measures physiological parameters such as heart rate and respiratory rate to improve the detection and response to young people and children who are at risk or have become more unwell. We did not have the opportunity to review any of these charts during our onsite inspection.

The Quality Network for Inpatient (CAMHS) Standards for Services (Royal College of Psychiatrists) standard (2.3.3) documents that all medical and registered nursing staff that administer rapid tranquillisation should complete Immediate Life Support training or local equivalent. Immediate life support training teaches more advanced skills than basic life support training including airway management. We can see in evidence provided that 92% of registered nurses and 88% of healthcare support workers have completed paediatric basic life support training. We asked senior managers for training compliance for paediatric immediate life support, who advised that staff receive basic but not immediate life support training. A requirement has been given to support improvement in this area.

The National Child Inpatient Psychiatric Service Annual Report (2024/2025) describes that restrictive eating due to mental health illness can be more varied and

complex in young people under the age of 12. It also highlights that Ward 4 has seen a higher incidence in admissions due to restrictive eating in recent years. This includes admission for Avoidant Restrictive Food Intake Disorder. This is an eating disorder characterised by the young person avoiding certain foods or types of food and may be due to reasons other than body image distortion, for example neurodevelopment difficulty or anxiety. We were provided with the Ward 4 Avoidant Restrictive Food Intake Disorder Pathway which describes the actions to be followed including during initial admission. This includes physical examination, dietetic assessment, psychiatric assessment and nursing care plan. It is documented that physical examinations and investigations that are required are aligned with the Royal College of Psychiatrists Medical Emergencies in Eating Disorders: Guidance on Recognition and Management.

Nutrition by artificial means and mealtime support

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 .

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 safe hold techniques to enable the administration of nutrition via the nasogastric tube.

The Mental Welfare Commission's good practice guide for nutrition by artificial means highlights that the 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 here. SIGN guidelines (2022) 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 (Scottish Intercollegiate Guidelines Network) 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 Ward 4 the Commission reviewed young people's care records in relation to the legal authorisation of treatment as noted earlier in this report. Senior managers advised us that there are fortnightly pharmacy meetings where young people's medication prescriptions are reviewed including documentation relating to legal authorisation of treatment. We observed that all medications were stored securely during our onsite inspection.

The NHS Greater Glasgow and Clyde Specialist Children's Services Ward 4 Nasogastric Feeding policy highlights that artificial nutrition via nasogastric tube is an essential clinical intervention to provide nutrition and medication to young people on the ward who are unable or unwilling to eat. This could be due to anorexia nervosa, catatonia, Avoidant Restrictive Food Intake Disorder (ARFID) and psychosis. It also documents that whilst it can be lifesaving, it should always be as a last resort. The policy includes the competency-based training log for staff undergoing training. NHS Greater Glasgow and Clyde Nasogastric Tube Position Confirmation record enables recording of volume of nutrition administered, tube length and PH of aspirate. Aspirate should always be obtained from the nasogastric tube prior to commencing nutrition to ensure correct placement in the stomach. We can see in evidence provided that 88% of nursing staff have completed training in the insertion and use of nasogastric tubes with two others currently undertaking training. Senior managers advised that recording of nasogastric tube placement has been added to the mental health combined care assurance audit tool from October 2025. We were provided with the completed audit from October which shows 100% compliance. Documentation and the combined care assurance tool are discussed later in this report. No young people were receiving nutrition via nasogastric tube during our onsite inspection.

During our onsite inspection staff told us that an incident report is submitted each time a safe hold is required to administer artificial nutrition via nasogastric tube. Staff also advised that a separate incident report will be submitted for each administration even if the same young person requires nutrition three times a day. We can see that approximately 35% of incident reports submitted in relation to safe holds are for the administration of nutrition via nasogastric tube.

The Ward 4 Information Pack for parents/carers documents that mealtimes are protected and visiting should be avoided at this time unless the young person is part of the eating disorder programme and families/carers are involved in their mealtime support. It is also documented that staff encourage mealtimes to be sociable with staff joining young people for all meals. However, it is also documented that this may not be suitable for all young people and in these instances an alternative room can be utilised. We asked senior managers for the number of staff who are trained in mealtime support who advised that mealtime support training is included in all nursing staff induction programmes.

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.

Approximately six percent of all incidents reported in the six months prior to our inspection relate to staff having to intervene to stop or prevent young people from harming themselves. The Ward 4 annual report for 2024 – 2025 documents a fall of 57% in reported incidents relating to self-harm. Senior managers advised that suicide and self-harm prevention is part of mandatory training for Ward 4 staff. We can see in evidence provided that approximately 84% of registered nursing staff have completed a suicide prevention training programme.

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 the NHS Greater Glasgow and Clyde Safety Health and Wellbeing (SHaW) Risk Assessment Form for the management and reduction of risk for Ward 4 which was completed in August 2025. 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. These include risk assessment and care planning, 15-minute environmental checks and consideration of the use of continuous interventions if assessed as required. Actions required include the development of a care plan in relation to the use of a specific piece of equipment. We raised this with hospital managers who advised this is currently under review.

Evidence provided includes the recommendations from the Quality Network for Inpatient (CAMHS) QNIC review for Ward 4 from March 2025. This includes a recommendation to install parabolic mirrors in the ward corridors to enable better visibility. We can see that it is documented in the QNIC action plan that approval to purchase these has now been agreed. We asked senior managers for an update on this who advised that a company is due to review the work required.

NHS Greater Glasgow and Clyde utilise electronic patient care records including a Child and Adolescent Mental Health specific risk assessment tool (FACE CARAS). This provides a structured assessment to enable clinicians to assess and manage risk for young people. This includes one general risk profile schedule and 10 additional focused risk schedules

that can be completed. These include aggression risk, vulnerability risk and self-harm and suicide risk schedules. The SHaW risk assessment highlights that any young people assessed as being at risk would be supported with enhanced interventions. We were also provided with the Ward 4 Self harm Control Checklist (environmental) and General Risk Assessment Form – Patient Self Harm Form. These describe further mitigations including the development of individual care plans, reduced ligature fixtures and fittings where able, and daily staffing review to ensure adequate skill mix. The self-harm control checklist is a risk assessment designed to identify and assess any environmental features that may be used by young people to harm themselves. The level of risk also uses a risk matrix of low, medium and high risk. We can see that these have been completed and include documentation regarding mitigation.

Continuous interventions

Continuous intervention is an enhanced level of care implemented when a patient has been assessed as having 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.

During our onsite inspection staff told us of the implementation of NHS Greater Glasgow and Clyde 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 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. 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 the 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 an area to document the reason if not discussed. As part of our onsite inspection, we were able to review some health records

of young people and observed that the continuous observation care plans were up to date and reviewed daily. As noted earlier in this report the Commission also reviewed young people's care records.

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. Please see here for further information. Staff confirmed to inspectors as they had done to Commission visitors that NHS Greater Glasgow and Clyde do not currently have a board wide seclusion policy. As noted by the Commission earlier in this report Ward 4 utilises a local guidance document which is in line with the Commission's good practice guide. The Ward 4 guidance documents highlights that the decision to implement seclusion should only be made by a member of the medical team or nurse in charge and must be in response to a clearly identified risk of significant harm. The guidance includes a record of seclusion form which enables documentation of person authorising seclusion, if safe holds were used, events leading up to the implementation of seclusion and if a seclusion care plan was completed. There is also a section to record the time that senior managers or medical staff were informed of the implementation of seclusion including the on call manager if out of hours. We asked senior managers if these forms are audited who advised that as of yet they had not been audited, but that this is planned as part of the ward's next documentation audit schedule. However, we were not provided with a timeline for this. During our onsite inspection staff told us that NHS Greater Glasgow and Clyde are in the process of developing a board wide seclusion policy with some of Ward 4 staff being involved in this.

Approximately 15 percent of incidents reported in the six months prior to our inspection relate to the use of seclusion. The Ward 4 seclusion guidance documents two types of seclusion. Level 1 where a young person is secluded within a room alone and should only be used as a last resort and Level 2 when staff remain with the young person whilst they are secluded. Level 2 can also include placing restrictions on the young person's physical environment with the intention to keep them separate from others. We can see that the use of the "chill out" room for seclusion is documented in several incident reports. The Ward 4 seclusion guidance also discusses the use of the chill out room for Level 1 seclusion. During our onsite inspection we observed that the room is a low stimulus room with cushioned walls and floors and a stable type of door that enables the top part to be left open which also has a window to enable observation if the door is closed.

The Royal College of Psychiatry Network for inpatient child and adolescent standard 1.1.8 (2025) documents the standards that should be met for rooms used for seclusion. For more information please see here. Evidence provided includes the recommendations from the Quality Network for Inpatient (CAMHS) QNIC review for Ward 4. This highlights that the 'chill out' room is not suitable for seclusion as it does not meet all of the

standards required due to there being no window to provide natural light, no direct access to toilet/washing facilities and no clock. Actions documented include adding the chill out room to the Ward 4 risk register. We can see in evidence submitted that this has been added and it is highlighted that the room does not meet the QNIC minimum standards for rooms used for seclusion. We discussed this with senior managers who advised that a refurbishment of the room is currently in the planning stage with ongoing discussions with NHS Greater Glasgow and Clyde estates team. A requirement has been given to support improvement in this area.

Physical health care

We asked senior managers how young people's physical health was monitored who advised that Ward 4 has a full-time paediatrician who monitors physical health. We were also advised that the majority of nursing staff are competent in venepuncture if required. The NHS Greater Glasgow and Clyde Mental Health Service Physical Healthcare Policy describes that all young children admitted to Ward 4 should have a full physical assessment on the day of admission. We asked senior managers who completes these out of hours who advised that this would be undertaken by the on call psychiatric medical team. We were advised that in the case of a medical emergency staff would call 2222 for immediate response. The 2222 number is an emergency number used within NHS hospitals which connects to the switchboard to activate an emergency response. As part of their visit the Mental Welfare Commission reviewed young people's care documentation including in relation to physical health. Please see the experience of care and treatment section of this report for further information.

Documentation

As previously discussed, we, together with the Commission, were able to review patient records during our onsite inspection which were up to date and complete. This included risk profiles which highlighted risk and included a risk management plan. We observed person-centred care plans and pass plans which used accessible language and format such as the use of pictures. We saw evidence of input from the multidisciplinary team including documentation of the weekly multidisciplinary team meetings and involvement of young people and their carers.

NHS Greater Glasgow and Clyde utilise a mental health combined care assurance tool to audit aspects of care including patient care documentation. 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 Ward 4 for February 2025 which has an overall score of 99% with high scores throughout. However, we can see in the corresponding action plan that not all documentation was completed consistently. This included nutritional fluid charts not being completed and calculated at the end of each day, care plans not being reviewed on planned dates and specific risk assessments not always completed. Documented actions

for improvement include refresher training for risk assessments, emails to nursing staff and further audit by charge nurses. A requirement has been given to support improvement in this area.

We can also see from the care assurance audit tool for February 2025 that it is documented there was no system in place to confirm young people's identity if they were unable to do so themselves. During our onsite inspection 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 discussed this with senior managers who advised that this has been discussed with nursing staff to ensure photographs are taken to upload onto the young person's electronic prescription chart. 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. We can see in the October 2025 audit that it is documented that there is now a system in place to confirm young people's identity if they are unable to do so themselves.

Care environment and infection control and prevention

We observed that the care environment was bright, clean, well maintained and uncluttered although staff told us it does get hot during the summer due to the amount of windows. Outdoor spaces in mental health wards play a crucial role in patient wellbeing, recovery, and overall therapeutic care. Ward 4 has a secure outdoor area which we observed being used by a young person. Domestic staff we spoke with told us they feel supported by the team and have adequate supplies. We observed that cleaning products were stored securely.

Dignity and respect

All observed interactions between young people and staff were positive and respectful.

Staff told us that each young person has a key nurse. However, it is noted earlier in this report that young people spoken with by the Commission reported not knowing who their individual key nurse was. The Ward 4 Roles and Responsibilities of the Key Nurse document highlights that on admission or earliest opportunity that the key nurse will introduce themselves to the young person and their family/carers. Roles and responsibilities of the key nurse include ensuring documentation is up to date on admission, sharing key information with families and young people such as ward routines and policies, ensuring care plans are person centred and to facilitate 1:1 meetings with the young person. Staff told us that where able, young people will have three 1:1 meetings a week which are factored into the young person's timetables. We were also advised that 1:1 meetings are recorded in the young person's care records. The key nurse roles and responsibilities document also highlights that initial 1:1's can be used to support the young person to complete their 'all about me' booklet. The booklet enables young people to record information about themselves such as if they have any

siblings or pets. It also includes information on the young person's favourite colours, animals, movies and hobbies and activities they enjoy. We asked senior managers who would complete the 1:1 if a young person's key worker was on annual leave who advised that each young person has a key worker team which includes three nursing staff and a charge nurse.

Approximately 10% of incidents reported were due to staff having to intervene to stop or prevent young people from assaulting their family members/carers or other young people. Documented actions include use of continuous interventions, low stimulus environment and discussion with the multidisciplinary team and updating of the young person's care plan. We asked senior managers what support was in place for young people who had witnessed stress and distress. Stress and distress can include agitation, anxiety and aggression. We were provided with the Specialist Children's Service Debrief for Young People document which highlights its purpose as being to provide a clear trauma informed approach to debriefing children following incidents. Trauma informed practice includes recognising where people are affected by trauma and responding in ways that prevent further harm. It is documented that debriefs should be offered following any form of physical intervention such as seclusion or safe holds, following any event that the young person has found to be significantly distressing and at the request of the young person or family/carer. The document defines a debrief as a structured and supportive conversation following an incident to help those involved reflect and process the incident. Senior managers advised that the debrief policy is followed to enable young people to have the opportunity to reflect, share their experience and receive appropriate support. We were advised that whilst formal feedback of the process has not yet been gathered it is part of ongoing monitoring to identify any areas for improvement.

Staff told us that mobile phone access is restricted for young people. The patient use of personal mobile phones Ward 4 Local Protocol documents that there is a requirement to ensure appropriate access to mobile phones, in particular access to internet and social media, in order to maintain the safety and wellbeing of young people. It is also documented that mobile phones that have camera and sound/video recording capability have potentially significant implications for individual privacy as may be used to take photographs or recordings of other young people or staff. On admission young people will be informed of the mobile phone guidance with their phones being kept by their families/carers. Young people can access their mobile phones during visiting times, however, it is documented that it is the responsibility of parents/carers to support safe social media use. The guidance includes the hyperlink to parentzone.org to provide parents/carers with support and advice on parental control and settings. The Ward 4 mobile phone protocol has a place for the young person, their parent/carer and ward staff to sign to say they are aware of the mobile phone guidelines. Ward 4 has available laptops and electronic tablets that young people can access under supervision.

Mixed sex accommodation can have an impact on dignity and personal choice. As previously discussed, two of the bedrooms in Ward 4 are double rooms. However, only one double room is considered for shared occupancy. Senior managers advised that due

to capacity the second bed in the double room was very seldom used. We were also advised that there is no formal risk assessment for the use of the second bed. However, senior managers advised that each young person's individual risk assessments would be considered when assessing which young people would be suitable to share. We were also advised that the second bed may be utilised for a young person who is on a pass. Senior managers also advised that if sharing this would always be young people of the same gender.

Ward 4 has restricted access with entry being via swipe card access. Senior managers advised that this is to prevent unauthorised access. We can see in evidence provided that movement in and out of the ward is based on individual care plans and risk assessment and that due to children being under the age of 12 that it would not be appropriate for them to leave the ward unaccompanied. It is also documented that swipe card access is only required on entering the ward. We observed that there was signage outside the ward on how to contact staff for entry.

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

Areas of Good Practice

1. Recommendations made by the Commission following previous visits to Ward 4 have been addressed and this is welcomed.
2. During our visit to Ward 4, the multidisciplinary staff team told us that they enjoyed their various roles, felt valued and worked in partnership to do the best for the young people in their care. They also acknowledged constructive managerial support and having the resources to enable them to deliver high quality, individualised care and treatment. Staff also told us of the availability of reflective practice and debrief for all staff.
3. Importantly, the reported experience of young people, families and staff visiting Ward 4 confirmed the quality, person-centred care the staff team aimed to achieve. We found that this experience was underpinned by a committed and compassionate multidisciplinary staff team, quality care planning and lawful treatment.
4. All observed interactions on Ward 4 were respectful, caring and person-centred.
5. Information available to young people was accessible and bespoke based on age and stage to maximise.
6. There has been the implementation and trial of a number of quality improvement initiatives including talking mats to aid communication between staff and young people.
7. Ward 4 has weekly community group meetings which are held by the young people and facilitated by nursing staff. There is also provision of available detailed digital online information resources for young people and their families/carers.
8. There has been a recent increase in the multidisciplinary team establishment including, psychology, occupational, speech and language and family therapy and nursing staff.
9. Ward 4 staff facilitate a Skills Sharing Network to enable the sharing of knowledge, skills and experiences from members of the multidisciplinary team.
10. NHS Greater Glasgow and Clyde have recently implemented a continuous intervention guidance which includes a person-centred care plan.
11. We were provided with the Specialist Children's Service Debrief for Young People document which highlights its purpose as being to provide a clear trauma informed approach to debriefing children following incidents.

Areas for improvement

1. An NHS Greater Glasgow and Clyde seclusion policy needs to be in place to underpin the use of the seclusion room on Ward 4.
2. Anyone has a right to make an advance statement, and we recommend that Ward 4 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 prioritised to meet national standards.

NHS Greater Glasgow and Clyde must ensure all improvement actions within fire risk assessments are completed to include but not limited to repair and replacement of defective fire doors (see page 23).

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 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 34).

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 all staff who administer rapid tranquillisation have completed immediate life support training or equivalent (see page 35).

This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 and Quality Assurance Framework (2022) Indicator 2.14 and 6.1 and Quality Network for Inpatient CAMHS Standards for Services (2021) Criteria 2.3.3.

NHS Greater Glasgow and Clyde must ensure that rooms used for seclusion meet Quality Network for Inpatient CAMHS standards requirements (see page 14 and page 41).

This will support compliance with: Quality Assurance Framework (2022) Indicator 2.2,2.4,4.1,6.1 and 6.2 and Quality Network for Inpatient CAMHS Standards for Services (2021) Criteria 1.18 and Health and Social Care Standards (2017) criteria 5.19.

NHS Greater Glasgow and Clyde must ensure that all documentation is completed consistently, including nutritional fluid charts, care plan reviews and risk assessments (see page 42).

This will support compliance with: Quality Assurance Framework (2022) indicator 2.6, 4.1 and 6.1 and relevant codes of practice of regulated healthcare professionals.

Next Steps

The visit/inspection of Ward 4 at the National Child Psychiatry Inpatient Unit resulted in 11 areas of good practice, two recommendations and five requirements.

A requirement in the 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 recommendations. 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 organisation's 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.

Further information about the methodology for safe delivery of care inspections can be found on our website. Child and Adolescent Mental Health Inpatient Services inspection programme – Healthcare Improvement Scotland.

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] Carers, consent, and confidentiality

[3] https://www.gov.scot/publications/child-adolescent-mental-health-services-camhs-nhs-scotland-national-service-specification/pages/3

[4] 6. Principles and Standards for Independent Advocacy Reflecting Commissioners' Statutory Responsibility - Independent advocacy: guide for commissioners - gov.scot

[5] SocialCircumstancesReports_GoodPracticeGuide_2022_1.pdf

[6] https://www.gov.scot/publications/national-standards-mental-health-officer-services/

[7] A holistic approach focusses on the person as a whole; their health, their circumstances, what matters to them rather than on separate individual aspects of their care.

[8] https://www.nice.org.uk/guidance/ng10

[9] Rights, risks and limits to freedom

[10] https://www.nsc.org/getmedia/a291988d-7fc6-4fbc-98f3-76ac5f7f0570/patient-restraints-english.pdf.aspx

[11] MedicalTreatmentUnderPart16MHA_2021_0.pdf

[12] About the QNIC network

[13] AdvanceStatements-2024.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, January2016)
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, November2022)
15. Person Centred Care Plans (Mental Welfare Commission, August2019)
16. Person-centred care (Nursing & Midwifery Council, December2020)
17. Preparation of care plans for people subject to compulsory care andtreatment (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)