Mental Welfare Commission for Scotland

Report on announced visit to:

The Melville Young People's Mental Health Unit, Royal Hospital for Children & Young People, 50 Little France Crescent, Edinburgh EH16 4TJ

Date of visit: 1 April 2021

Where we visited

The Melville Unit for young people with mental illness has 12 inpatient places for adolescents with mental health problems. It is a specialist tier four service designed for young people aged 12 to 17 years (inclusive). The beds are primarily intended for Lothian patients, with specific agreements to take patients from Fife and the Scottish Borders. There is also a more general agreement to take patients from other Scottish health boards on an emergency basis. At the time of our visit the unit had 12 patients, 10 of whom were detained. There were also three patients on the waiting list for a place.

The unit had moved from the Royal Edinburgh Hospital site on the 15 January to the new Royal Hospital for Children & Young People (RHCYP). There had been a long engagement with builders of the new hospital to ensure the new unit met the needs of young people with mental health care needs.

There is a multidisciplinary team comprising of a psychiatrist, psychologists, nurses, a family therapist, dietitians, art therapist, music therapist and occupational therapists in place. The young people are referred for education to the hospital school. There is also access to other professionals, as required, on referral.

We last visited this service on 14 November 2018 and made a recommendation regarding the need to review consent to treatment documentation during multidisciplinary review meetings.

On the day of this visit we wanted to follow up on the previous recommendation and also look at how the ward was settling into the new environment and how they have coped during the Covid-19 pandemic. We were aware there had been many senior staff changes and that the ward consultant psychiatrist had been off shielding due to the pandemic. This had meant locum medical cover alongside higher medical trainees and a part time staff grade doctor being in place for most of the last year.

Who we met with

We met with and/or reviewed the care and treatment of four patients and three relatives.

We spoke with the new service manager, the interim senior charge nurse and a charge nurse as well as the locum consultant psychiatrist.

Commission visitors

Margo Fyfe, Nursing Officer

Claire Lamza, Interim Executive Director

Alyson Patterson, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

During our last visit to the service we were pleased to see that previous recommendations regarding case files and care plans had been taken on board. At that time we found care plans to be person centred and inclusive of the young person's views.

On this visit we were informed that all care planning was now on the electronic system TRACK. On viewing the files we found that daily notes continued to have information on how the young person spent their day with some indication of their mental state. However, when viewing care plans we were disappointed to find these lacked information and focussed on only one aspect of care need, with no real sense of the young person or indication of their involvement in compiling the plan, or agreement with the plan. We could not find any clear link to the multidisciplinary meetings with regard to review or care plan changes. We also heard from relatives that they are not given the opportunity to see written care plans or to have copies of these where the young person is happy for this to happen. We suggested that a paper care plan is done for each young person who would then be given a copy and that this is then made available to families when they young person is happy for this to happen. We would like to see a review of the current care planning system to ensure young people and their families are clear about the care and treatment in place and going forward.

The Commission has produced good practice guidance on person-centred care plans which can be found at:
https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Multidisciplinary Meetings

We took the opportunity to look at the notes on the TRACK system from the multidisciplinary reviews. In doing so we could not see links to information from young people or their relatives reflected in these notes even when we found clear information from young people and relatives in the paperlite files. We also did not see any clear information or care plan in place where continuous intervention was in place for a young person. It is our view that multidisciplinary meeting notes should detail the discussions had, note the people involved in the meeting, and have clear links to care plans, care reviews and forward plans.

Recommendation 1:

Managers should ensure that care plan audit and reviews are carried out and that young people are included in the making of care plans. The young person should be given a copy of their care plan and families should be given to opportunity to see care plans with the consent of the young person.

Recommendation 2:

Managers should review the recording of multidisciplinary notes to ensure they accurately detail attendees and the points discussed. The staff in attendance should ensure that there

are clear links to care planning and forward planning of care and treatment as well as reflecting input from young people and their families.

Use of mental health and incapacity legislation

When reviewing notes we took the opportunity to look at mental health legislation paperwork. We were able to locate detention paperwork within the paperlite files. We also looked at consent to treatment forms to ensure these were in place appropriately. We found that there was, in some cases, quite a time lapse between the use of T4 forms which are used when emergency treatment of detained patients is required and when a second opinion review was requested. We are clear that at most a T4 can cover treatments for up to two weeks whilst awaiting a second opinion review. We recommend that the use of T4s is reviewed and that clarity is given to all medical staff on the use of these consent forms and when second opinion reviews are required.

Recommendation 3:

Medical staff should review the use of T4 consent to treatment forms ensuring that second opinion reviews are requested promptly.

Rights and restrictions

Locked door

During our visit we saw that the door to the new unit is locked. We were informed that the door is locked to ensure the safety of the young people by preventing anyone who should not be on the ward from walking in freely. It also ensures safety when there are young people in the unit that may put themselves at risk by leaving unaccompanied. There is a policy in place, and young people and parents are informed of this at time of admission.

Policies

We were shown the room purpose built for seclusion and informed it is never used. However, we were clear that as the room exists on the ward there should be a clear policy covering its use in place. We were able to look over the existing policy relating to the use of seclusion and were informed this will be updated to reflect the current situation. We look forward to seeing the updated version on future visits to the unit. We saw that the practice of young people and families being given a copy of the mobile phone policy on admission and being asked to sign their agreement to abide by this policy remains in place.

As at the time of our last visit we noted that discharge documentation including pass plans are now in use, however these are not always being completed. We suggest that the documentation is reviewed at multidisciplinary meetings to ensure it is accurately detailing a young person's progress towards discharge, including time off the ward on pass. We look forward to seeing how this has progressed at future visits.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

On previous visits to the old unit we had raised concerns about the lack of organised activity on the ward. However, when we last visited we found this had improved and that there were clear plans in place for more off ward activity with the occupational therapy staff.

During this visit to the new unit we were disappointed to see a lack of activity again. We understand that nursing staff are very much involved in supervision of meals and post meal monitoring as there is such a high number of patients with eating disorder diagnosis. However, we did see young people sitting around doing nothing. We were informed that occupational therapy time is split between the unit and the day programme which limits the amount of time available for activity with them. During the visit we were unaware of occupational therapy staff being on the ward. However, we are aware that there are groups and 1:1 sessions offered to the patients and that these are not always accepted by the patients. We understand that Psychology are planning a group programme but this had not yet started. We suggested that a clear activity programme is devised between occupational therapy and nursing staff to encourage participation and avoid boredom for the patients as well as prominently displaying occupational therapy groups on offer throughout the week.

We also look forward to hearing more about the psychology input to the unit at future visits.

Recommendation 4:

Managers should ensure that occupational therapy input to patient care is clear within care files and that a clear activity plan including occupational therapists and young people's views is put in place.

The physical environment

As the unit is new, everything is well maintained. The communal areas have windows/doors onto the enclosed garden with artificial skylights in the ceiling. This makes the area a little dull. There is a nurses' desk in the communal area which unfortunately attracts staff rather than staff sitting with the patients. It is not clear why this desk is in place as there was no desk like this in the old unit. We suggested having this removed if possible to encourage staff and patient mixing, and we look forward to seeing how the space has been adapted and used during future visits.

All bedrooms are in one long corridor. Rooms are single, of a good size with ensuite facilities. There is one room out with the main corridor that is adapted for disabled use. This room can be used as an intensive care area and has a smaller room attached that can be used as a sitting room.

There is an enclosed garden area that is accessed from the communal areas of the ward. At the time of our visit the door was locked and it took some time to locate keys and open the door. We saw that there are issues in supervising patients in the garden as there is an area that cannot be seen from the entry to the garden. We also noted there are hilly areas in the middle of the courtyard that would prevent the area from being used for any group games. We suggested the outside space is reviewed for safety and use. We look forward to seeing how this space is adapted and used in future visits.

Any other comments

Comments from parents

We heard from parents that they really like the environment within the new unit as everything is fresh and new. They also highly praised the work of nursing staff recognising the hard work they do. However, there was clear agreement that the communication from multidisciplinary meetings and in particular from medical staff has been poor. We were told of parents not being able to meet with consultant psychiatrists for considerable periods of time and of young people not being seen by the consultant psychiatrists for quite a while into their admission. There was also unhappiness at not getting to see care plans and not being assured that there was robust care planning in place.

We found these issues to be concerning. We would expect all consultant psychiatrists to participate fully in assessment and care of a young person whilst under their care in an inpatient facility. We would also expect medical and nursing staff to communicate regularly with families to ally anxieties and ensure they can participate in a young person's recovery appropriately.

Staffing

We were made aware of medical staff cover for the unit being difficult over the last year and will write to the Medical Director separately regarding our concerns in this area.

We heard that there have been changes in senior nursing staff and look forward to seeing the impact of the new staff team at our next visit.

Recommendation 5:

Medical and nursing staff should ensure they have regular scheduled time to communicate with families in regard to care and treatment of patients. The current systems in place for this should be reviewed urgently to ensure a more robust communication system is in place.

Summary of recommendations

1. Managers should ensure that care plan audit and reviews are carried out and that young people are included in the making of care plans. The young person should be given a copy of their care plan and families should be given to opportunity to see care plans with the consent of the young person.
2. Managers should review the recording of multidisciplinary notes to ensure they accurately detail attendees and the points discussed. They staff in attendance should ensure there are clear links to care planning and forward planning of care and treatment as well as reflecting input from young people and their families.
3. Medical staff should review the use of T4 consent to treatment forms ensuring that second opinion reviews are requested promptly.
4. Managers should ensure that occupational therapy input to patient care is clear within care files and that a clear activity plan including occupational therapists and young people's views is put in place.
5. Medical and nursing staff should ensure they have regular scheduled time to communicate with families in regard to care and treatment of patients. The current systems in place for this should be reviewed urgently to ensure more a robust communication system is in place.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

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

ALISON THOMSON
Executive Director (Nursing)

About the Mental Welfare Commission and our local visits

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

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

When we visit:

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

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

In addition to meeting with people who use the service we speak to staff and visitors.
Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

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

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

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

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

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

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