Mental Welfare Commission for Scotland

Report on announced visit to: The National Child Inpatient Unit, Ward 4, Royal Hospital for Children, 1345 Govan Road, Govan, Glasgow G51 4TF

Date of visit: 16 November 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's route map (May 2020). There have been periods during the pandemic where we have been able to conduct our face-to-face visits; however, the reinstatement of lockdown required us to review this, and we are presently undertaking a variety of face to face and/or virtual visits. This local visit was able to be carried out face-to-face.

The National Child Inpatient Unit is the nationally commissioned child psychiatry unit for Scotland. The ward provides six inpatient beds and admits children from all over Scotland who are aged 5–12 years, although there is some flexibility at either end of the age range based on clinical need. The service is located on the top floor of the Royal Hospital for Children building on the South Glasgow University campus.

We last visited this service on 3 December 2018 and made two recommendations about the service. Firstly, we recommended that hospital managers should review the clinical record standards to ensure that the process of reviewing care plans is sufficiently robust and is applied consistently. Secondly we recommended that hospital managers review Mental Health Officer (MHO) cover for the unit so that MHO provision for patients is sufficiently clear and co-ordinated particularly when a child patient comes from a local authority area located distally from the unit, and where there are likely to be difficulties in fulfilment of MHO duties from the local area due to distance.

Our main reason for visiting on this occasion was to obtain an update on the service and learn more about how the unit has responded to the challenges of providing care within the restrictions in place due to the Covid-19 pandemic. We are aware that during the initial lockdown of 2020 for a period of approximately three months in early summer the ward patients and staff moved to be co-located within Skye House, the West of Scotland regional specialist adolescent inpatient unit, as a means of using resources (including staffing) wisely and efficiently in an attempt to deliver effective care to children and young people during the constraints of the lockdown provisions. On the day of this visit we also received an update on the plans to develop the unit's inpatient provision so that two of the six beds will become resources for children who have an intellectual disability as part of national development in specialist child and adolescent learning disability services.

Who we met with

We reviewed the care of all four children who were inpatients at the time and spoke with three children and two parents or carers.

We spoke with the service manager and senior charge nurse (SCN) and briefly with one of the two consultant psychiatrists who work at the unit.

The Commission visitors were

Dr Helen Dawson, Medical Officer
Ms Kathleen Liddell, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

In previous visits the feedback we have obtained from the child patients and their relatives or carers is usually very positive and we received similar feedback this year. Key themes in the feedback we obtained was that the children felt very safe and cared for within the unit with individual children telling us that they knew that staff genuinely cared about them and were trying to help them get better. Family members similarly told us that they found staff thoughtful and supportive and that there was a real commitment to collaboration and inclusion of families within the unit. Once again, carers and relatives told us they felt actively involved in the management of the young people on the ward and felt staff were receptive to their comments and feedback.

Care records are of a very high standard with the use of the problem list facility within the electronic management system (EMIS) now being used to help structure the hospital records and facilitate review of key pieces of documentation such as care plans. We found the work undertaken by the ward team in developing this facility to be extremely helpful in our ability to quickly and accurately access records in a targeted fashion. There was good evidence of care plan reviews taking place on a regular basis. We were pleased at the examples of good practise shown in the use of child friendly care plans which were clearly constructed together with the child themselves. These provide an opportunity for the child's care to be informed by the child's own views and represent an opportunity for genuine involvement and engagement of the child in their care. As in previous visits, we found the care plans to be patient centred and comprehensive.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:
https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

The physical environment

The ward is located on the top floor of the Royal Hospital for Children. It appears clean, bright and in good decorative order with murals and wall art sensitively placed within the ward environment. The walls within the unit have information presented in a child friendly fashion to help orientate the children to the activities on the ward and timetable for that day. The walls at the entrance provide information about the ward and provide helpful information for visitors including governance information about the ward and also practical information about local places to visit for those visitors unfamiliar with the area.

Within the ward there are a number of rooms available for recreation for inpatients and a room in which a number of children can watch television together. An indoor soft play and sensory room is available and both of these rooms act as valuable resources when the children are

unable to go outside. An art room is available, which many of the patients can use and on the same floor as the ward is an outside play area which appears popular and well maintained. In addition, there is an outdoor play park for children at ground level adjacent to the hospital building which the children can access with ward staff. The patients receive school provision within the unit by the hospital's education team in reflection of the measures put in place to combat Covid-19. The activities relating to education form an important aspect of most children's daily timetables.

Work remains at the early stages in reconfiguring the ward accommodation to respond to the needs of future inpatients which will include children with an intellectual disability. Changes are planned to adapt a number of bedrooms and bathroom facilities and adapt a number of ward rooms to be able to cater for the needs of all the ward population at the same time. Adaptations to the play area have been identified and facilities for laundry are to be developed also on the ward.

One of the aims of the forthcoming alternations is to provide a multipurpose room which is large enough to cater for all the child inpatients as a whole and flexible enough to be able to be adapted to a number of purposes. Given the high proportion of child inpatients who can have neurodevelopmental difficulties or children whose social interactions before admission have been heavily curtailed, we look forward to hearing about the impact of the multipurpose room in future visits, together with the benefits that other developments in the ward accommodation have been able to bring.

Use of mental health and incapacity legislation

From the information we reviewed during our visit we had no concerns about the use of mental health legislation for the children who are presently inpatients within the unit. We are aware that sometimes matters surrounding the use of legislation for children and can be complex and we are aware that sometimes MHOs attending the ward have little or no experience of using mental health legislation in children 12 years and under. It was good to hear that the ward has made links with one of the training schemes for MHOs and that trainee MHOs have visited the ward in the past in order to learn about the use of the mental health act in children and young people.

It is disappointing to learn that no progress has been made with respect to the matter surrounding MHO cover for the unit for areas which are distant from Glasgow. We are aware from previous experience that sometimes there may be difficulties in being able to get timely access to MHOs when consideration is being made about the use of compulsory mental health legislation for the child inpatients. It was good to hear that the MHO who is based in Skye House and has a good range of experience in the use of compulsory measures in children and young people under the age 18 years is sometimes available to provide support when there are difficulties but there are no arrangements in place for when this MHO is on leave. One of the challenges in addressing this issue is that the problem may arise in an unpredictable manner with a low frequency of occurrences over the course of any year. At the same time the problem when it does occur can be substantial and, given the importance of the MHO role in the use of compulsory measures and the fact that the unit is shortly to expand

its range of patients to include those children with an intellectual disability, this time of national service review and development may provide a crucial opportunity to visit this issue formally.

Additionally, through our work during the year and from our visit on this occasion we were made aware of difficulties that can be experienced in the arrangement of local authority community care packages when children are discharged. We therefore would recommend exploration of MHO cover for the unit should be undertaken alongside consideration of social work provision within the unit as part of the core multidisciplinary team to provide social work support for child inpatients and their families and help support liaison with local authorities during discharge planning.

Recommendation 1:
Hospital managers should explore cover arrangements for MHOs for the unit to ensure there is clarity and agreement regarding the responsibilities for MHO provision to the unit for those situations when the respective MHO team may be too geographically distant to attend the ward in an appropriate time frame. Additionally, consideration should be given to expanding the multidisciplinary team to include social work expertise to support children and their families as inpatients and support liaison with local authorities at the time of discharge.

Rights and restrictions

The ward has a number of areas that are locked and prevent egress and entry onto the ward without appropriate permission. Staff told us that there have been no difficulties with access to, from or within the unit and they felt the correct balance had been achieved internally between doors providing necessary barriers to limit access and doors providing unnecessary obstacles to appropriate movement.

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

Therapeutic Activity

The core multidisciplinary team (MDT) that supports child inpatients includes provision from psychiatry, nursing, psychology, systemic family therapy, speech and language therapy, occupational therapy, physiotherapy and specialist dietetics. At present the systemic family therapy post remains unfilled. The unit's team also includes a link nurse who is an experienced member of staff whose main focus is to support communication and joint working between the child, the clinical team, the child's family or carers and whichever agencies may be involved with the child including education, social work or community Child and Adolescent Mental Health Services (CAMHS).

We found evidence of good interdisciplinary working on the ward and we noted multiple examples where visual supports were in use to support therapeutic goals and scaffold periods of time for the child inpatients. Each week every child has their activity including therapeutic

activity for the forthcoming week reviewed and informed by their care plan. Every week a planner that is readily visible for the child is created which outlines their activities each day and the times of their meetings with members of the MDT. Each child has a key nurse with whom they meet on an individual session each day. The ward also has a number of regular group activities which includes an art class run by the an art teacher from the hospital educational team and also a community group which meets each week and keeps children up to date of any news or developments on the ward.

Summary of recommendations

1. Hospital managers should explore cover arrangements for MHOs for the unit to ensure there is clarity and agreement regarding the responsibilities for MHO provision to the unit for those situations when the respective MHO team may be too geographically distant to attend the ward in an appropriate time frame. Additionally, consideration should be given to expanding the multidisciplinary team to include social work expertise to support children and their families as inpatients and support liaison with local authorities at the time of discharge.

Good practice

We were pleased to see the work that the clinical team has undertaken in developing child friendly care plans to promote inclusion of the child inpatients in their care and to ensure their care plans take cognisance of their views. We also noted the high quality of the care planning and record keeping in general within the ward and the efforts made within the constraints of the EMIS system to support efficient navigation of notes and records.

We also commend the attempts made by the clinical team to provide opportunities for MHOs in training to learn about the use of compulsory measures in the under 12s which can be a complex area at times.

Service response and action plan

The Commission requires an action plan to this recommendation within three months of the date of this report.

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

SUZANNE MCGUINNESS
Executive Director (Social Work)

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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