Mental Welfare Commission for Scotland

Report on an unannounced 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: 27 April 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

The Melville unit has 12 in-patient beds for adolescents with mental health problems. It is a specialist tier four service designed for young people with mental ill health, 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 an 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 two patients on the waiting list for a place.

The unit moved from the Royal Edinburgh Hospital site on the 15 January 2021 to the new Royal Hospital for Children & Young People (RHCYP).

There is a full multidisciplinary team in place. The young people are referred for education to the hospital school. There is also access to other professionals, as required, and on referral.

We last visited this service on 1 April 2021 and made recommendations regarding care plans, recording of multidisciplinary notes, the review processes of consent to treatment forms and communication with families/carer

On the day of this unannounced visit we wanted to follow up on the previous recommendations and also look at how the patients and staff were adapting to the new environment and how they have coped during the Covid-19 pandemic.

Who we met with

We reviewed the treatment of eight patients, meeting seven of the young people in a group setting and one relative.

We spoke with the clinical nurse manager (CNM), the senior charge nurse (SCN), the consultant psychiatrist (RMO), two charge nurses, an occupational therapist (OT), physician associate and art therapist.

Commission visitors

Kathleen Liddell, social work officer

Margo Fyfe, senior manager (practitioners)

What people told us and what we found

Comments from patients and relatives

The young people we spoke to on the day of the visit were generally positive about the care and treatment in the unit. One young person told us that the care in Melville unit had been the best care they had experienced since being referred to the CAMHS services.

We were told that each young person has their own room and that they can personalise if they choose. Those that we spoke to told us that now Covid-19 restrictions have eased, they have regular contact with their family/carer which is positive. We heard from the young people that they are encouraged to attend meetings about their care and treatment adding that their family/carers can also attend.

We heard that staff were supportive and that the young people felt safe in the ward setting. We were told that staff shortages can present problems, especially at weekends when bank and agency staff tend to cover the majority of shifts. Some of the young people told us that they did not feel as safe or supported when bank and agency staff were on shift; these staff do not have the same understanding of their care and treatment plan as regular staff. Relatives that we spoke to were of the view that multiple changes in staff has contributed to a lack of consistency in their child's care.

We were pleased to hear from the young people that they are supported to attend school while they are an in-patient in the Melville unit. Some of the concerns raised by young people were in relation to education and how this may be affected as the timetable is part-time.

The parent we spoke to on the day of visit was positive about the care in the Melville unit, telling us that staff were supportive. The parent raised some concerns over staff shortages and the impact of this, especially at meal times when some of the young people required additional and therapeutic support. We heard from the parent that they found the meal choices to be limited and would like to see more options being made available on the menus. The parent was also of the view that a keyworker system for the young people would improve communication and consistency in care.

We heard that there is a carers group for support however the timing of this created some difficulties for working parents to attend. The SCN told us that there is a carers' leaflet explaining support available to them, which was compiled in association with Vocal Carers Group.

Care, treatment, support and participation

The atmosphere in the ward was welcoming and calm during the visit. We noted that the staff we met with on the day of the visit knew the patients well. The ward was busy with some young people engaging in group and arts and crafts activities. We observed some one-to-one interactions between staff and young people which were positive.

On the day of the visit, there was a community meeting that most of the young people attended. The community meeting is held weekly to discuss all ward-related issues and is facilitated by social work and nursing staff. There is a suggestions box in the ward for young people who find it difficult to communicate in a group setting.

The CNM and SCN told us that there continues to be staff shortages, especially with registered nurses. There is currently only one responsible medical officer (RMO)/approved medical practitioner (AMP) on the unit which has had a negative impact on medical reviews and service provision. We were told that managers have been considering options to support current staffing in the Melville unit and have recently recruited two occupational therapy posts which will be dedicated to the ward and managed by the SCN in Melville unit. Alongside these posts, managers are interviewing for additional posts that will support the registered nursing staff. A bed manager post has been recently appointed and this is viewed as positive by all staff that we spoke to on the day of the visit.

We were told that in terms of staff support, there is a fortnightly reflective practice session facilitated by psychology. There are times when nursing staff are unable to attend due to staffing levels. There is an additional fortnightly meeting for ward nurses in the unit, to discuss their issues, which are then escalated to managers. The SCN told us that nursing staff are transparent about current areas of difficulty in the unit and communicate this at meetings.

We made a recommendation in the previous report that a scheduled time for communicating with family/carers should be arranged. We were disappointment to hear that there are ongoing communication issues that contribute to family/carers increased anxiety, especially in relation to future planning and discharge. We were told that it can take long periods of time for staff to provide responses to young people and their family/carers. Family/carers told us that they would find a named nurse arrangement beneficial for consistency in care and to promote regular communication.

Recommendation 1:
Managers should urgently ensure that there are alternative arrangements for communicating with family/carers. The current systems in place must be reviewed to ensure more frequent communication.

The Commission requires a response to this recommendation within a month of receiving this report.

Multi-Disciplinary Team Meetings
Care and treatment in the ward is provided by the multi-disciplinary team (MDT). The MDT comprises of nursing staff, 1 RMO, a senior trainee (ST6) doctor, psychology, physician associate, occupational therapists. Dieticians, family therapy, art therapy, psychotherapy, pharmacy, education and social work. While this is an extensive MDT, we were concerned to hear of the low number of medical staff available on the unit.

MDT care plan review meetings are held every two weeks which is a change from the previous arrangement of weekly meetings. The recording of the MDT meetings are detailed with clear decisions and action plans for the young people in the unit. However, we noted there was a lack of discussion about discharge planning in the MDT meetings. We discussed this with the CNM and SCN on the day of the visit; we provided advice that discharge planning should be discussed at the point of admission and reference should be made to this at all MDT meetings.

We noted that there were gaps in the recording of the MDT, especially in relation to social work and family therapy and would suggest that these are included at the meetings.

The young people, family/carers and some of the staff we spoke to on the day of the visit told us that the MDT meetings are not frequent enough. Our concerns are that without frequent MDT's there may be delays in decision making and raised frustration and anxiety in young people and their family/carers.

On review of the young people's notes, we noted that there is a record of a meeting of professionals that takes place every Monday. This meeting makes decisions regarding care and treatment planning. We raised our concerns with the CNM and SCN that decisions about care and treatment of young person were taking place without the presence of the young person or family/carer. Section 2 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) sets out principles that apply to children and young people. The principles are clear that it is necessary to take account of the wishes and feelings of young people and the views of their family/carers.

https://www.gov.scot/publications/mental-health-care-treatment-scotland-act-2003-code-practice-volume-1/pages/2/

Recommendation 2:
Managers should urgently review the level of medical provision in the unit.

Recommendation 3:
Managers should review the frequency of the MDT meetings in order to provide maximum benefit to the young person and their family/carers.

Care Plans

We reviewed notes, including care plans and risk assessments, which are held both electronically and in paper copy. We found the risk assessments to be of a good standard. We made a recommendation in the previous report in relation to care plans lacking information. We were disappointed to see that the care plans continue to lack detail, were not person centred and did not have any clear links to the MDT outcomes. The care plans we reviewed did not evidence the involvement of the young people or take into account the wishes or views of the young person and their family/carer. All of the young people we met with during the visit told us that they were not actively involved in their care plan and had not seen a copy of it. Some young people did not know that they had a care plan.

We discussed this with the CNM and SCN, highlighting our concerns that the recommendation about care plans in the previous report had not been progressed. The CNM told us that audits of the care plans have highlighted these as areas of ongoing progress required. The CNM and SCN told us that there are plans to develop the current care plans, including the introduction of new staff to the ward who will have a role in completing and reviewing care plans. The introduction of a local structured clinical assessment tool (SCAMPER) is intended to improve communication of the young person's progress in the ward as well as improving the key clinical tasks to be completed for the young people, in order to ensure that their care progresses without gaps or delays.

We did find that the continuation notes were informative and personalised, indicating the young person's progress; in particular, one-to-one interactions with psychology and OT were comprehensively recorded. There was limited evidence of one-to-one interactions between the young people and nursing staff; we raised this with the SCN on the day of the visit. The

SCN told us that these interactions did take place between nursing staff and young people on a regular basis however acknowledged the recording of these interactions is poor.

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/node/1203

Recommendation 4:
Managers should ensure that there is increased participation of the young people and their relatives/carers in care planning. Care plans should be linked to MDT decisions and include discussions regarding discharge planning.

Recommendation 5:
Managers should ensure that care plans are regularly audited and reviewed.

Use of mental health and incapacity legislation

On the day of our visit, 10 patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA). We found the forms relating to each young person's detention stored electronically on TrakCare, the electronic record system used on the ward.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Where consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were required, we reviewed the electronic and paper files and found all the appropriate forms were in place and prescribed medication was authorised.

None of the patients in the Melville Unit had an advanced statement in their file. We found that patients had limited knowledge of what advanced statements are therefore not having the opportunity to make decisions and choices about their care and treatment. We discussed with the CNM and SCN the responsibility health boards have for promoting advanced statements as they are a way of ensuring that young people with mental ill health are listened too and their rights respected. We made suggestions of how advanced statements can be promoted in the ward and the importance of recording the reasons if a patient declined an advanced statement.

On the day of the visit, there were no patients recorded as requiring restrictions to be placed upon them under Sections 281-286 of the Mental Health Act. From the notes we reviewed, there was evidence of additional restrictions being placed on young people, for example, in relation to items being removed from a young person's room for their safety. We provided advice to the CNM and SCN that these restrictions should be authorised under section 286 of the Mental Health Act and relevant paperwork completed.

Rights and restrictions

During our visit we saw that the main door to the Melville unit is locked. We were told this was for the safety of the young people in the unit and should an informal patient request to leave, they would be able to do so. We were told that there is a locked door policy in place. On the day of the visit, the policy was not accessible and we made a suggestion that this policy is displayed at the door to ensure young people and their family/carers have easy access to it.

We noted in the previous report that there was a purpose-built room for seclusion and we were informed it was never used. We were told that the existing seclusion policy was being revised and that a draft version has been completed. We viewed the room and saw that it was not in use. The SCN told us that the team are considering a more therapeutic use for this room and we look forward to seeing progress of this in future visits.

Of the patients we met with, we found that they had a mixed understanding of their rights and we found that there was not enough positive action being taken to inform patients of these. From the files we read and young people we met with, we were concerned that none of them had had any recent contact with advocacy services. The role of advocacy services is essential in assisting young people to understand their options and convey their views. We discussed, with the CNM and SCN, the duties of the health board under Section 259 of the Mental Health Act, in securing the availability of independent advocacy services and ensuring the young people have the opportunity to access these services. The SCN advised that she was in the process of setting up weekly drop-in advocacy sessions on the ward.

We were pleased to hear that the Patient Council have started to attend the ward recently and offer collective advocacy to patients.

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

Recommendation 6:
Mangers should ensure that rights based care in relation to legal status is given to the young people and recorded in patient care plans.

Recommendation 7:
Managers should ensure that the young people in Melville Unit have the opportunity to make use of advocacy services to assist in expressing their needs, thoughts and views.

Activity and occupation

There is an activities board displayed on the wall of the unit. On the day of the visit, there were visible gaps on this board, especially in the evenings and weekends. This was reflective of the lack of organised activity recorded in the young person's care plan and of the views of the young people that we spoke to on the day of the visit.

Most of the young people in the unit attend school in the mornings. OT's are currently responsible for offering the majority of group and individual activities to young people on the ward, out with school times. At present, OT staff cover all CAMHS in-patient and community services. We met with an OT on the day of the visit and were told that OT's meet with the young person on admission and discuss interests. OT's offer to meet the young person weekly which is not always accepted by the young person. The files we reviewed evidenced a high level of OT involvement with the young people.

Art and music therapy is offered to young people on the unit individually and as a group activity. The young people we spoke to told us that they do not like some of the current ward-based activities and have fed this back to the staff via the community meetings. We discussed

this with the CNM and SCN and they are aware of the views of the young people and have fed this back to the facilitators of the group.

We were told that many of the activities are art based and at times not age appropriate. We were told that if the young person does not have an interest in art, their activity options are limited. The young people we spoke to on the day of the visit told us that there are no iPads on the ward and only one games console, which is currently broken. There is a TV in the communal area with Netflix however, as a result of poor WiFi preferred TV programmes cannot always be accessed. The issue of poor WiFi has been addressed with the internet provider and building estates however, it remains an issue that causes frustration to young people and staff.

We heard from staff and young people that there are pamper/relaxation sessions and movie nights on the unit, mainly in the evenings; these are popular. We did not see any record of these activities documented in the files or care plans we reviewed. We discussed with the CNM and SCN that activities should be recorded as part of the young person's care plan and linked to outcomes and decisions made by the MDT.

We heard from CNM that in order to provide an increased level of activity in the ward, two additional OT's have recently been recruited. These posts will be dedicated to the ward and will be part of the wider ward team inputting into assessment, care plans and reviews. The SCN told us that there are planned new initiatives to support increased activity on the ward, such as the gardening project. We look forward to seeing the progress of these initiatives in future visits.

The physical environment

The unit remains well maintained. There are individual rooms with en-suite facilities; rooms are personalised with the young people's belongings. All bedrooms are located in a long corridor that does not have much natural light. There is one room out with the main corridor that is adapted for young people with additional physical care needs. There are windows in each bedroom that look onto a garden area. We noted that the garden area is overgrown and requires maintenance.

Nursing staff told us that during environmental checks, there are some blind spots in the bedrooms and the snug area within the communal space. These concerns have been raised with the appropriate managers and will continue to be reviewed.

On the last visit, we raised safety concerns over the outdoor space as there are blind spots and a hilly area in the middle of this space preventing it being fully used. We made a suggestion that the outdoor space be reviewed for safety and use however we were disappointed to hear that no progress had been made and the area remains underused due to safety concerns. The SCN advised that she shares the same concerns and has escalated these concerns to managers.

We were encouraged to hear that the SCN has made a funding proposal to the climate change fund for a gardening group that will make improvements to this outdoor space.

We made a suggestion during the previous visit that the nurse's desk in the communal area be moved in order to facilitate staff sitting with the young people, rather than at a desk. We

were disappointed to see that the desk remains in the same area and creates a potential barrier to young people approaching this staff. We made a suggestion to the CNM and SCN that further discussion is required on how to better use this space.

Any other comments

From the staff we spoke to, we were told that working through the Covid-19 pandemic has had a negative impact on staff's ability to undertake their role in the ward. We were impressed to see and hear how the staff have continued to maintain the service despite numerous challenges, including staff shortages.

We were also pleased to see recruitment initiatives that will further support staff such as the role of the patient co-ordinator post that will have responsibilities in bed management.

Summary of recommendations

1. Managers should urgently ensure that there are alternative arrangements for communicating with family/cares. The current systems in place must be reviewed to ensure more frequent communication.

2. Managers should urgently review the level of medical provision in the unit.

3. Managers should review the regularity of the MDT meetings in order to provide maximum benefit to the young person and their family/carers.

4. Managers should ensure that there is increased participation of the young people and their relatives/carers in care planning. Care plans should be linked to MDT decisions and include discussions regarding discharge planning.

5. Manager should ensure that care plans should regularly audited and reviewed.

6. Mangers should ensure that rights based care in relation to legal status is given to the young people and recorded in patient care plans.

7. Managers should ensure that the young people in Melville Unit have the opportunity to make use of advocacy services to assist in expressing their needs, thoughts and views.

Good practice

We were impressed to see a new project has been introduced to the unit recently influenced by the safewards model. At the entrance of the unit, there is a discharge tree and hive of positivity display. The objective of the discharge tree is for young people to provide views on their experience in the Melville unit and to use these views and comments to improve the experience of the young people in the unit.

The hive of positivity is a colourful display that has hopeful and inspirational quotes chosen by the young people. The next stage being worked on is mutual expectations that will involve input from the young people, their family/carers and staff to share their views and experiences of the Melville Unit.

Service response to recommendations

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

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

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

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

The Commission visits people in a variety of settings.

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

When we visit:

- We find out whether 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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