Mental Welfare Commission for Scotland

Report on an 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: 29 August 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 11 patients, 10 of whom were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA). On the day of the visit, there were nine patients on the ward, one patient on pass and one patient had been transferred to a paediatric ward for medical treatment.

The Commission last visited this service on 27 April 2022 and made recommendations in relation to the auditing and review of care plans, increased participation of the young people in their care plans, urgent review of medical provision in the unit, improvements in communication with families/carers, reviewing the frequency of MDT meetings, increased access to advocacy services and improved evidence of rights based care.

The Commission planned to visit the Melville Unit in April 2023 to follow up on these recommendations, meet with young people, their parents/carers and staff to hear about their experiences as well as look at the care and treatment being provided on the ward, however in August 2022 the Commission received information from clinical staff highlighting significant concerns in relation to the young people's care and treatment in the unit, specifically incidents of missed nutrition. We were advised that senior managers were aware of these concerns and were involved in contingency planning to ensure the young people were receiving the care and treatment recorded in their care and treatment plans. We therefore arranged to carry out this visit in order to meet with as many young people and staff on the unit as possible, to hear about their experiences and any concerns they had about the care and treatment being provided and to review their clinical records.

Who we met with

We met with six young people and reviewed the treatment of all nine young people on the ward. Unfortunately due to the very short notice of our visit, we were not able to meet with any parents/carers on the day.

We spoke with the clinical service manager (CSM), clinical nurse manager (CNM), staff nurses, consultant psychiatrists (RMOs) and the associate physician. We also spoke with the local advocacy services that provide input to the ward and across the clinic, social work mental health officers (MHO's) and social workers for the young people.

Commission visitors

Kathleen Liddell, Social Work Officer
Lesley Paterson, Senior Manager, east team (Practitioners)
Anne Buchanan, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Comments from young people

The young people we spoke to on the day of the visit reported a range of views about their in-patient experience. All of the young people we met with were able to identify staff members in the ward that they felt were supportive, approachable and offered them assistance when required. We were told that the introduction of OTs in the ward had been positive, as they were able to spend one-to-one time with young people, engaging in activities.

We were also told by some young people that some staff did not listen to them, their views were not taken into consideration or respected and they were unware of their rights in relation to their detained status. The young people told us that there are long periods of the day that they have no structured activities and feel "bored".

The young people we spoke to told us that the unit is short staffed and is regularly staffed with bank and agency nursing staff, especially at the weekends. They told us that many of the bank and agency staff are not trained to carry out some of the tasks recorded in their treatment plans, specifically nasogastric (NG) feeding. As a result, there have been times when these treatments have not being carried out. The young people told us when the unit is short staffed, it causes staff on shift to be "stressed". We were told the some of the young people have felt "traumatised" after NG feeds, due to being physically restrained and staff adopting a '"heavy handed" approach at times. The young people told us that after these difficult experiences, they did not receive any post-restraint or post-feed support; they felt that staff had no awareness of the psychological impact of having an eating disorder. We were also told by some of the young people that they had missed NG feeds due to staff shortages and felt angry about the inconsistent message being given to them by staff. The young people added that they are told by staff that they "must have" a certain amounts of NG feeds in a day however when the unit is short staffed, the NG feeds are not given. We heard that at least one of the young people had experienced a deterioration in their physical health following missed feeds. Those who had missed NG feeds told us that this was very distressing for them as they are aware that at some point they would have to make up the calorie deficit and "this hangs over them". The young people added that they are rarely told when NG feeds would happen or how much would need be administered. The young people did not feel this was person-centred care, finding this approach anxiety-provoking and punitive.

The majority of the young people we met with had a diagnosed eating disorder. We met with some young people who had other mental health diagnoses and they told us that they feel that they "did not fit in" and do not get as much support and time from staff as the patients who had an eating disorder. This was evident when we reviewed the nursing notes. The young people who do not have an eating disorder tended to spend long periods of time in their room, which raised concerns over increased isolation.

All of the young people we met with told us that meals times in the unit were unpleasant. The young people told us that there was no choice of meals and at times they had to eat meals they did not like. Many of the young people require 'meal support' from staff and we were told that there were occasions when staff did not display positive modelling behaviour, for

example, making comments about their own eating habits; the young people did not find this supportive and at times it was "triggering". For young people who do not have an eating disorder, we were told that the dining room can be a difficult and tense environment to eat and enjoy a meal.

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/carers, 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. The young people we spoke to raised concerns that although they are invited to attend the weekly meetings, they are invited in at the end of the meeting for a 10-minute slot and feel as though this is very rushed and that decisions have already been made by this point. They added that the 10-minute slot is solely to inform them about the decisions which have been made and does not allow for participation in decision-making. One of the young people told us that they do not feel as though they have any control over decisions being made about their care.

Recommendation 1:
Managers should ensure there is meaningful participation of the young people and their relatives/carers in care planning and decisions about their care and treatment and this participation is recorded within their clinical record.

We were pleased to see that some progress has been made since our last visit, given the current difficulties. We observed some warm interactions between staff and young people. The staff we spoke to know the young people well and were committed to offering them high levels of care throughout their admission.

Care records

During our visit, we looked at the young people's information that is held on the electronic recording system 'TrakCare'. We found that the recording of care records is not consistent, with some staff using a pre-populated template with headings to record information. We found that notes recorded on this template were more detailed, personalised and provided better information on the young person's progress. We found that the young people who had a diagnosed eating disorder had more comprehensive detailed records in comparison to young people who have a different mental health diagnosis. We were concerned by the limited information recorded in the care records of these young people.

There was evidence of one-to-one interactions between young people and staff, more specifically OT, psychology and the associate physician. It was evident from the care records that nursing staff spend the majority of their time engaged in tasks related to the physical health care needs of the young people. There was a notable lack of opportunity for nursing staff to have regular therapeutic interventions with the young people.

We found some care records that detailed communication with families and relevant professionals however, this was limited and there was a lack of evidence of families/carers being actively involved in discussion and decision-making. Following the visit, the Commission made contact with MHO and social work professionals who are involved with some of the young people in the unit. The professionals we spoke to told us that

communication with the unit could be improved and they were concerned that important information, such as missed nutrition, had not been passed to them.

Nursing care plans

Nursing care plans are a tool which identify detailed plans of nursing care. Good care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made. We reviewed the care plans and risk assessments which are stored electronically on TrakCare. We found the risk assessments to be comprehensive and of a good standard. We made a recommendation in previous reports in relation to care plans that lacked detail, not being person-centred or personalised and not having clear links to multidisciplinary team outcomes. We were disappointed to see that there has been no improvement to nursing care plans. We found limited evidence of the young person's or family/carer involvement and participation. 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. The care plans did not record measurable goals and outcomes and there was limited evidence of a discharge framework.

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

We discussed the care plans with the CNM on the day who told us that audits of the care plans have highlighted that ongoing progress is required. We were told during the previous visit that the new staff employed in the unit would have a role in completing and developing care plans. We were told by the CNM that new staff have been identified for this role however staff shortages have impacted on the development of care plans. The CNM added that there is work currently being undertaken with the IT services in relation to TrakCare, to develop a care plan template specifically for CAMHS; the objective of this being an improvement in the quality of the care plans.

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 2:
Managers should ensure nursing care plans are person-centred, contain individualised information, reflect the care needs of each person, identify clear interventions and care goals and evidence patient participation.

Multidisciplinary team (MDT)

Care and treatment in the Melville Unit is provided by the MDT which consists a full and a part-time RMO, nursing staff, psychologists, associate physician, dieticians, family therapists, art

therapists, psychotherapists, pharmacists, education and social work. The young people are referred for education to the hospital school.

While this is an extensive MDT, we made a recommendation in the previous report that the medical provision in the unit should be reviewed. We were pleased to be told that the ward now has an additional three days a week of consultant psychiatry input in place.

The CNM told us that staffing in the unit continues to be problematic due to staff retention and sickness issues. There are currently two Band 6 charge nurse vacancies. Bank and agency staff are used regularly, especially at weekends. The CNM told us that the senior management team have been considering ways to support the staffing crisis and have arranged for Band 5 staff nurse to be brought into the ward from the community as a temporary measure. The assertive outreach team are also supporting the unit at meal times. We were told that the ward will be employing an additional five newly qualified paediatric nurses. Whilst employing paediatric nurses is encouraging, unless they also have a mental health nursing qualification, they will require a great deal of support and supervision to work with children and young people with complex mental health presentations. Since the previous visit, two OTs have been employed and this has been a welcome addition to the staff team.

On the day of the visit we spoke to various staff in the unit. All staff we spoke to told us that they find the current staffing situation in the unit extremely difficult. Some of the staff told us that it was “physically impossible” for them to complete all tasks recorded on the care and treatment plans of the young people. We were told that some of the treatments have been missed, such as NG feeds. Nursing staff that we spoke to told us that they were unable to form any kind of therapeutic relationship with young people, as they spent all of their time undertaking task-focused work, such as NG feeding. Some staff told us that they do not feel the ward is always a safe environment for them to work and they are concerned that they will “lose their nursing registration” due to deficits in care.

All of the staff we spoke to on the day of the visit highlighted concerns over some of the senior management team. We were told that some senior managers set unachievable treatment goals and have unrealistic expectations of the care and treatment staff can offer to the current patient group in the unit. Staff working in the unit do not feel listened too or part of any decision-making about the unit; this results in them feeling undermined and undervalued. Some of the staff we spoke to told us that they were actively seeking alternative employment.

In terms of staff support, we were told that reflective practice sessions facilitated by psychology are available. None of the staff we spoke to on the day of visit had been able to attend these sessions recently due to staff shortages, however agreed they would be beneficial. Nursing staff told us that they felt supported by SCN and CNM however given the workload of these senior nurses, they did not have the capacity to offer regular professional or clinical supervision.

We made a recommendation in the previous report in relation to the frequency of the MDT meetings which were taking place fortnightly. We were pleased to hear that MDT meetings now take place weekly. As well as the weekly MDT meetings, a professionals meeting takes place on a Monday. We raised the concerns from the previous report, about decisions regarding care and treatment planning that were taking place at these meetings, without the

young people and their family/carer being present. The CNM told us that on a Monday, meetings are used to pass on information from the weekend and to confirm the young persons' care planning for the week ahead.

We were concerned to hear that nursing staff rarely attend MDT meetings due to staff shortages. Nursing staff we spoke to on the day of the visit told us they were not part of the discussions or decision-making for the young people they provide direct care to. We were told by nursing staff that they did not always agree with decisions made by the MDT; we were concerned at the lack of nursing input into this meeting. We raised our concerns with the CSM and CNM on the day of the visit who agreed that it was important for nursing staff to attend the MDT and be part of the meeting and they will continue to make efforts to support nursing staff to attend these.

The recording of the MDT meetings are detailed with clear decisions and action plans for the young people in the unit. We were told SCAMPER has recently been introduced to record MDT meetings. SCAMPER is a structured clinical assessment and communication tool intended to highlight key clinical tasks to be completed for the young people and to ensure that their care progresses without gaps or delays. We saw some evidence of SCAMPER being used and were told that the use of SCAMPER is work in progress. We provided advice during the previous visit that discharge planning should be discussed at the point of admission and reference should be made to this in all MDT meetings. Although there was some improvement in this area, we would like to see more evidence of discharge planning at the earliest possible stage.

Family/carers told us during the last visit that they would find a named nurse arrangement beneficial for consistency in care and to promote regular communication. We were pleased to see that the ward is now divided into four groups, each group has a key nurse and a co-nurse. Some of the young people we spoke to on the day of the visit told that they found this arrangement beneficial in ensuring consistency of care. We were also pleased to note that the RMO and CNM had sent out a letter to the family/carers in the unit providing updated information. The CNM told us that the unit will continue to make efforts to improve communication with family/carers.

Recommendation 3:
Managers should review the MDT meeting format to ensure representation and participation of all key disciplines involved in care and treatment delivery.

Recommendation 4:
Managers should ensure that there are suitable arrangement in place for communicating with family/carers.

Recommendation 5:
Managers should explore the current professional relationships between all disciplines in the MDT in order to overcome any inter-professional conflict and promote effective and collaborative working, which should positively impact patient care.

Use of mental health and incapacity legislation

On the day of our visit, 10 patients were detained under the Mental Health Act. We found the detention certificates relating to each young person's detention stored electronically on TrakCare.

Part 16 (sections 235 to 248) of the Mental Health Act sets out conditions under which treatment may be given to detained patients who are either capable or incapable of consenting to specific treatments. Treatment must be authorised by an appropriate T2, T3 or T4 certificate to evidence capacity to consent. On reviewing the electronic and paper files we were disappointed to find that some patients did not have valid certificates authorising treatment that some of the certificates which were in place did not correspond with the prescription kardex and there was confusion over where these certificates were stored. We raised this with the CNM on the day of the visit and requested an urgent review of all consent to treatment certificates.

Section 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to these sections of the Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. On the day of the visit, we were told that no young people were recorded as requiring restrictions to be placed upon them. On review of the young people's files, we noted that one young person was a specified person. We were initially unable to locate the relevant paperwork to authorise the restrictions however the paperwork was eventually located. We discussed with the CNM that we would expect any restrictions to be legally authorised and relevant paperwork completed and stored in the young person's file. We also highlighted the need for specific restrictions to be regularly reviewed with the reasoned opinion recorded and in accordance with the principle of least restriction.

Our specified persons good practice guidance is available on our website at: https://www.mwcscot.org.uk/node/512

Recommendation 6:
Managers and the responsible medical officers must ensure that all psychotropic medication is legally authorised and nursing and medical staff know where these certificates can be accessed.

Recommendation 7:
Managers should introduce an audit system ensure that all medication prescribed under the Mental Health Act is authorised appropriately.

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.

Of the patients we met with, we found that they had a mixed understanding of their rights. We noted in files that some of the young people have legal representation and advocacy support. When reviewing files, we found letters to the young people who are detained under the Mental Health Act, providing information on the order they were subject to and information on how to exercise their rights. We were pleased to see some improvement in promoting rights, however there was little evidence of the young people being informed of their rights on a regular basis in the care records or at MDT meetings. We would like to see more positive action being taken to regularly inform young people of their rights.

When we are reviewing patient files we look for copies of advanced statements. The term 'advanced statement' refers to written statements made under ss274 and 276 of the Mental Health Act, and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. On the day of the visit, none of the young people who we met with had an advanced statement in their file. We had discussed this with the CNM and SCN during the previous visit, explaining to them the responsibility health boards have for promoting advanced statements, as they are a way of ensuring that people with mental ill health have their rights respected; it gives them the opportunity to record their decisions and choices about their future care and treatment. We were told by the CNM that following the previous Commission visit, staff have been discussing ways that they can encourage and support the young people to complete advanced statements. This work is in the early stages and the Commission will continue to monitor this during local visits.

We made a recommendation in the previous report that the young people should have the opportunity to make use of advocacy service, Advocard. We were pleased to hear that this service now attends the ward on a weekly basis and provides a drop-in service on a Tuesday afternoon. We made contact with Advocard and they advised us that some young people do use the service, however felt that the drop-in could be better advertised in the ward and that it could be included on the weekly activities planner to ensure better use of the support. Advocard have asked the unit to reconsider the time of the drop-in as it is after lunch when many of the young people currently in the ward are on enhanced one-to-one observation.

Recommendation 8:
Managers should ensure that rights based care is delivered to patients, recorded in care plans and that information on rights is available to young people and is visible throughout the ward.

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

There is an activities board displayed on the wall of the unit. On the day of the visit, there were gaps on this board, especially in the evenings and weekends. This was consistent with the lack of organised activity recorded in the young person's care plan and with the views of the young people that we spoke to. Most of the young people described being 'bored' for long periods of the day and told us that there is very limited access to technology such as iPads, games consoles and mobile phones, which does not support them to feel connected to their peers. There is a TV in the communal area with Netflix however, as a result of a poor Wi-Fi signal, preferred TV programmes cannot always be accessed. The issue of poor Wi-Fi has been raised with the internet provider and building estates department however, it remains an issue that causes frustration to young people and staff.

Most of the young people in the unit attend school in the mornings. The young people that we spoke to on the day of the visit were very complimentary about the OTs involvement in their care, reporting that they offer them activities throughout the day. The files we reviewed

evidenced a high level of OT involvement with the young people. We observed the OTs engaging with young people on an individual basis and in small groups on the day of the visit. During the previous visit, we heard feedback from young people that they did not enjoy some of the activities in the unit. We were pleased to hear that these views were taken on board and some of these activities are no longer part of the timetable.

Recommendation 9:
Managers should ensure that patient activity plans are person-centred, reflecting the young person's preferences, desire to stay connected to their peers and offer a variety of activities specific to their care needs.

The physical environment

The unit remains well-maintained. All young people have their own individual bedrooms with en-suite facilities which are personalised with their 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.

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

On the last visit, we raised safety concerns in relation to 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.

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

Any other comments

The Royal College of Psychiatrists Quality Network for Inpatient CAMHS Standards for Services, 2021 and CAMHS NHS Scotland National Service Specification 2021, set out standards of care for CAMHS inpatient services. From the information gathered on the day of the visit and from speaking with the young people and staff, the Commission are concerned that the current care provided in the Melville Unit does not meet these standards and there is evidence of deficits in the care and treatment of young people that have, and could continue to, cause harm if urgent action is not taken.

Whilst there is evidence of a commitment to resolve current issues, it is not clear to the Commission how any resolution will be progressed given the perceived disconnect between senior managers and staff who provide the care in the unit to the young people. There is an urgent need for contingency planning to ensure that safe, person centred care is delivered to the young people and staff feel supported to undertake their role in the unit.

Summary of recommendations

Recommendation 1:
Managers should ensure there is meaningful participation of the young people and their relatives/carers in care planning and decisions about their care and treatment and this participation is recorded within their clinical record.

Recommendation 2:
Managers should ensure nursing care plans are person-centred, contain individualised information, reflect the care needs of each person, identify clear interventions and care goals and evidence patient participation.

Recommendation 3:
Managers should review the MDT meeting format to ensure representation and participation of all key disciplines involved in care and treatment delivery.

Recommendation 4:
Managers should ensure that there are suitable arrangement in place for communicating with family/carers.

Recommendation 5:
Managers should explore the current professional relationships between all disciplines in the MDT in order to overcome any inter-professional conflict and promote effective and collaborative working, which should positively impact patient care.

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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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