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: 28 September 2023

Where we visited

The Melville Unit has 12 inpatient beds for adolescents with mental health problems. Since the last Commission visit, the bed capacity had been reduced to ten, due to increased acuity and short staffing issues. The Melville Unit 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.

We last visited this service in August 2022 and made nine recommendations in relation to increased participation of young people and their relative/carers in care planning, person centred care planning, all key disciplines to attend multi-disciplinary team (MDT) meetings, improved communication with relatives/carers, medication to be legally authorised, improvements to patients activity plans to reflect interests/hobbies and exploration of the relationships between all disciplines in the MDT to promote positive and collaborative working.

On the day of this visit we wanted to follow up on the previous recommendations and meet with the young people, relatives/carers and staff to hear their views and experiences on how care and treatment was being provided on the ward.

Who we met with

We met with, and reviewed the care of eight patients, seven whom we met with in person and one discussion with a young person following the visit. We reviewed the care notes of eight young people. We also met with/spoke with seven of the relatives/carers.

We met with a variety of staff on the day of the visit including the general manager, clinical service manager, clinical nurse manager (CNM), senior charge nurse (SCN), nursing staff, CAMHS nurse consultant, psychology staff, family therapist, occupational therapist (OT), art therapist, social worker, patient co-ordinator and dietician. We offered to meet with the consultant psychiatrists however, neither consultant met with the Commission on the day of the visit. The clinical director join us at the end of day meeting.

We also had discussions with staff members prior to the visit who wished to remain anonymous.

We made contact with mental health officers (MHOs) and patient advocacy service, Advocard following the visit.

Commission visitors

Kathleen Liddell, social work officer

Lesley Paterson, senior manager (practitioners)

Juliet Brock, medical officer

Susan Tait, nursing officer

What people told us and what we found

Care, treatment, support and participation

Comments from the young people

The young people we spoke to on the day were mainly positive about their inpatient experience reporting that staff were kind, supportive and caring. We were told that the young people felt some staff listened to them, that they were involved in most discussions regarding their care and treatment and had some awareness of future planning. We heard that their responsible medical officer (RMO) met with them regularly, which they found beneficial.

Those that we spoke with had a good awareness of their rights in relation to their detained and informal status.

The young people told us that the unit was extremely short staffed and was regularly staffed with bank and agency nursing staff. They told us that having unfamiliar staff on the ward was anxiety provoking at times. Some young people did not feel confident that agency and bank staff had a good knowledge of their care and treatment plans and preferred working with permanent CAMHS staff who had the specialist skills and knowledge to deliver their care. Some of the young people told us that they did not always feel safe when the staffing in the unit was mainly bank and agency staff. This was particularly evident in the evenings and at weekends, or when some of the other young people were exhibiting stress and distressed behaviours.

We heard and saw the detrimental impact on patient care due to staff shortages. We were told by one person that they had missed some prescribed nasogastric feeds due to issues with staffing. Other young people told us that staff were often unable to facilitate agreed escorted pass time, which caused distress.

Most of the young people we met with attended the weekly multidisciplinary team (MDT) meeting. We heard that the young people found their attendance at the meeting mainly positive as they felt involved in discussions regarding their care and treatment. Some young people raised that they did not feel their RMO listened to their views. We heard that nursing staff did not always attend the MDT meetings, therefore they were unaware of decisions made. One young person described that information often got 'lost in translation' between nurses and the RMOs which had a negative impact on how care was delivered to them. Another young person told us that their pass time was regularly reviewed at the MDT meeting however, the decisions made were not communicated to nursing staff, leaving the young person feeling "stressed and confused" about pass planning.

Some of the young people told us that there were long periods of the day when they did not have much activity to do, especially at the weekend. Young people told us that the organised group activities in the unit were good however, they would like more of them. Many young people raised that that access to preferred TV programmes was limited due to poor Wi-Fi connection. We also heard there was a shortage of TV remote controls which young people found frustrating. We discussed this with the SCN who confirmed that remote controls were regularly damaged, however, new ones had been ordered.

We heard from some of the young people that the ward environment could become loud and intense at times due to incidents of verbal and physical aggression which some of the young people found traumatic. It was reassuring to hear from some of the young people that they mostly felt supported by staff at these times, however this was not consistent.

Comments from relatives/carers

The feedback from the relatives/carers we spoke to was mixed. Most relatives/carers told us that they felt their young person was well cared for and was happy with the majority of their care and treatment plan. Many of the relatives/carers reported that they felt supported by staff who adopted a supportive and caring approach. Some of the relatives/carers told us that communication with nursing staff was good and that they were updated on any changes. However, making contact with the unit and getting a quick response could be problematic due to staffing pressures.

All of the relatives/carers raised issues in relation to the unit being short staffed. We were told that staffing levels appeared to be reduced in the evenings and weekends resulting in concerns over the safety of young people overnight. We heard and saw that some essential care tasks such as prescribed nasogastric feeds and medication had been 'missed' as a result of the unit not having appropriate staffing, which was a significant concern to relatives/carers. Some relatives/carers were of the view that staff shortages should not be used as 'an excuse' for essential care not being delivered and were of the view that senior managers should take the concerns relating to the staffing crisis and the detrimental impact on patient care more seriously.

We heard from some relatives/carers that their young person had been distressed due to them witnessing high levels of acuity and aggression in the ward. Although relatives/carers had an understanding as to why these incidents took place, they felt that due to reduced and inexperienced CAMHS staffing, they had concerns over how these acute crisis situations were managed and the safety implications on the other young people.

Although most relatives/carers were of the view that attending the MDT was positive. Some felt the meeting was more of an 'information sharing forum' and there was no real opportunity to be involved in 'in-depth' discussion or decision-making. Some of the relatives/carers raised that nursing staff very rarely attended the MDT meetings and it could take time for the information discussed and decisions made in the MDT meeting 'to filter down' to nursing staff. Relatives/carers were unhappy with this arrangement as they felt the poor communication negatively impacted on their young person's care and treatment.

Many of the relatives/carers raised concerns over discharge planning. We heard about some 'failed discharges' which had caused families to feel anxious about future pass and discharge planning. Relatives/carers told us that they felt discharge planning was often contingent on bed pressures and waiting lists and the sole decision of the RMO, rather than the assessed needs and risks of their young person. We also heard that agreed plans at the MDT meeting relating to pass and discharge timeframes were often changed without consultation with the young person or their relative/carer. We heard that this caused additional stress and worry during what was an already challenging time for relatives and carers.

Many of the relatives/cares spoke positively about the new information/welcome pack that had been developed and provided prior to admission. In addition to this, there was a monthly newsletter that provided information about the unit. The weekly carers groups in the unit was also viewed as positive and supportive. We were pleased to hear that there had been improvements in relation to communication, the information provided to parents/carers, and the increased involvement some of them had in care planning.

A prevalent theme from discussions with young people and relatives/carers was significant staff shortages on the ward and the negative impact on patient care. We raised this with the CNM and SCN and were told that there were numerous vacancies throughout the MDT however, this was mainly problematic for registered nursing staff where there was a 50% deficit. As a result, bank and agency staff were used regularly in the unit and although every effort was made to use regular staff, this was not always possible. We also heard that many experienced nursing staff had left the MDT which had had a detrimental impact on the level of specialist CAMHS nursing knowledge and skill in the unit. The CNM told us that 11 newly qualified nursing staff had been employed and were due to start in the unit in October 2023. However, following the visit, we were subsequently told that only seven newly qualified nurses started and further recruitment will be pursued. The CNM told us that the new staff would be supported to undertake a CAMHS induction programme and there would be additional support available to them from the CAMHS nurse consultant.

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 were stored electronically on TRAK care. We found the risk assessments to be comprehensive and of a good standard. The risks were clearly recorded with a plan to manage each identified risk.

The nursing care plans we reviewed were of mixed quality. We were pleased to see that some improvements had been made from the previous visit in relation to increased levels of participation from young people and some evidence of person centred, strengths based and personalised information recorded. Some young people had been supported to complete a ‘Getting to know me’ form which promoted participation and a person-centred approach to care planning.

Other care plans we reviewed did not have the same level of quality information and were mainly prescriptive, with little evidence of personalised care or clear detail on the purpose of the nursing intervention recorded. For example, we found one care plan that recorded ‘support to be offered’ however, the care plan lacked detail as to what the specific intervention entailed or what the support was anticipated to achieve.

When reviewing the nursing care plans we were unable to locate robust reviews that included summative evaluation regarding efficacy of intervention, targeted nursing intervention or the individuals’ progress. We discussed the mixed quality of the care plans and reviews with the CNM and SCN on the day of the visit and were told that they were aware that ongoing

improvements on care planning and review was required. We heard that care plans were peer reviewed and audited however, due to staffing pressures, audits did not regularly take place.

We were told during the previous visit that IT staff in NHS Lothian were developing a care plan template specifically for CAMHS. We were disappointed to hear that no progress had been made in the development of this template. The CNM told us that plans for a specific CAMHS nursing care plan were ongoing.

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 1:
Managers should ensure nursing care plans are person centred, contain individualised information, reflect the care needs of each person and identify clear interventions and care goals.

Recommendation 2:
Managers should ensure care plan reviews are meaningful, include review of the effectiveness of interventions and reflect any changes in the individuals care needs.

Care records

During our visit, we looked at the young people's information that was held electronically on the IT system TRAK Care. We were pleased that improvements had been made in the quality of information recorded in care records. We saw evidence of more consistent use of the canned text to record daily activity. The majority of care records were comprehensive, person-centred and provided information on how the young person had spent their day, what activities they had engaged in and how they had found this.

It was evident from reviewing the care records that there were high levels of mental health acuity in the Melville Unit. The young people could experience high levels of stress and distress leading to increased clinical risk due to high levels of verbal, physical aggression and self-harm. We were pleased to note that the MDT were actively involved in providing the support, care and treatment to patients at these times.

We found that for young people with high levels of acuity and complex care needs, the recording was very detailed and comprehensive in comparison to the young people with less acuity. We found language such as 'evident on the ward' and 'no change' for these young people and were concerned by the limited information recorded in the care records and raised this with the CNM and SCN on the day of the visit.

The profile of the patients in the unit had changed significantly from the previous visit from mainly young people with an eating disorder to more acute mental illness. The change in patient needs required staff to adopt a change in skill set and knowledge which we heard had been challenging.

There was evidence of one-to-one interaction between young people and the MDT, more specifically OT, psychology and associate physician. We were pleased to note that there was

an increase in one-to-one intervention between the young people and nursing staff from the previous visit which supported building a therapeutic relationship.

We saw that physical health care needs were being addressed and followed up appropriately by the associate physician and we found improved levels of communication between families and relevant professionals.

Multidisciplinary team (MDT)

Care and treatment in the Melville Unit was provided by the MDT which consisted of a full and a part-time consultant psychiatrist, nursing staff, psychology, associate physician, dieticians, occupational therapy, family therapy, art therapy, pharmacy, education and social work.

MDT meetings took place weekly in the unit. Young people and relatives/carers were invited to attend MDT meetings and we saw evidence of them attending. We found detailed recording of the MDT discussion, decisions and future planning.

We raised concerns in the previous two reports that nursing staff rarely attended the MDT meetings and made a recommendation following the visit on 29 August 2022 that all key disciplines should be represented and participate in the MDT. We were concerned to hear and see that nursing staff's attendance at the MDT meetings continued to be rare. We spoke to many nursing staff who told us that they felt their attendance at the MDT was essential to support a fully collaborative and holistic approach to patient care and delivery. However, nursing staff told that they did not feel their attendance at the MDT was supported and prioritised by other members of the MDT. We were concerned to hear that nurses did not feel their nursing expertise or skills were valued in the MDT. We heard from young people and relatives/carers that the omission of nursing staff from the MDT meeting was felt to have a negative impact on their care and treatment on the ward. An example of this was a young person who shared their experience of their key nurse not being at the MDT meeting when a new diagnosis was given. We heard that this change to the care plan was not communicated to the nursing staff and resulted in the young person not receiving additional support when feeling distressed. We have concerns that this lack of cohesive and collaborative working significantly impacts on staff morale, communication and nursing staff's ability to provide holistic and person-centred care.

We previously highlighted concerns in relation to inter-professional conflict in the unit. We heard that some work had been done to address these issues. However, the feedback from the staff we spoke to was that no improvements had been made and the team dynamics were even more "fragmented" and "disconnected". This was evident to the Commission on the day of the visit. Many nursing staff told us that they felt "undermined", "don't feel valued" and "regularly overruled" by medical colleagues. We saw some evidence in the patient files of decisions being made by members of the clinical team in the RMO's absence, then being reversed by the RMO on their return, without evidence of wider MDT consultation.

We heard from many members of the MDT concerns regarding the senior management team. We were told by many staff that they had raised concerns regarding ongoing short staffing levels in the unit and the detrimental and at times unsafe impact on patient care. Staff told us they did not feel listened to by senior managers and felt that senior managers continued to have unrealistic expectations of the care and treatment staff could offer to the current patient

group in the unit. The majority of staff told us that staff morale was very low, making their working environment detrimental to their mental well-being. We are aware that many new staff have been employed and we heard from senior managers that measures, such as an extensive induction and supervision system were in place. We feel this is fundamental in ensuring these new staff are adequately supported, trained and retained.

We were pleased to hear that efforts had been made by the ward management team to support staff. There was a weekly team meeting with continuous professional development (CPD) incorporated. We heard that recent CPD had included sessions on autism awareness, self-harm and art therapy. We heard from staff that although they were encouraged to attend these meetings, they very rarely got the opportunity to attend due to staffing pressures.

We made contact with some MHO's following the visit. We heard that communication with nursing staff was positive. All of the MHO's mentioned the staffing pressures in the unit and that the young person they were allocated to had raised this as an issue of concern. Some of the MHO's had attended the MDT meetings and engaged in MDT discussion and decision. However, we also heard of occasions where MHOs had not been consulted prior to the RMO revoking compulsory treatment orders (CTO). Although the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) does not place a formal duty on the RMO to consult with the MHO, the codes of practice record clear guidance that it would be best practice for the RMO to remain in close consultation with the MHO and other members of the MDT, to enable the RMO to have all the relevant information when 'assessing the extent to which the care plan's objectives are being met'.

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

Recommendation 4:
Managers must explore the current professional relationships between all disciplines in the MDT in order to identify inter-professional conflict, consider effective strategies to overcome this 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, eight patients were detained under the Mental Health Act. We found the forms 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. This includes the requirement for a second opinion by an independent designated medical practitioner (DMP) for certain safeguarded treatments (such as artificial nutrition) and the authorisation of medications prescribed beyond two months, when the individual does not consent to the treatment or is incapable of doing so. Treatment must be authorised by an appropriate T3 certificate, or a T2 certificate if the patient is consenting.

We reviewed the prescribing for all young people, as well as the authorisation of treatment for those subject to the Mental Health Act.

Medication was recorded on the hospital electronic prescribing and medicines administration system (HEPMA). T2 and T3 certificates authorising treatment were stored separately on Trakcare. It is a common finding on our visits that navigating both electronic systems simultaneously can be a practical challenge for staff. This is potentially problematic, as it can reduce the ease of checking the correct legal authority is in place when prescribing or dispensing treatment for those who are detained. For this reason we suggested during the previous visit that a paper copy of all T2 and T3 certificates be kept in the ward dispensary, so that nursing and medical staff have easy access to, and an opportunity to review, all T2 and T3 certificates. We found that no progress been made with this, and that there was uncertainty among staff regarding where these documents were stored and therefore the difficulty navigating both systems remained.

On cross-checking the electronic records for each patient, we found that two detained patients were prescribed treatment that was not authorised on a T2 or T3 certificate, when these were required. We were particularly concerned that one young person had received unauthorised treatment for several months, with medication prescribed at maximum British National Formulary (BNF) dosage without the safeguard of a DMP second opinion being arranged, as legally required under the Mental Health Act. We also found that one young person had intra-muscular (IM) as required (prn) medication authorised on a T2 consent to treatment certificate. The Commission's view is that as required IM medication should be authorised on a T3, as in the event that an injection is required, it is unlikely that the patient would be consenting at the time.

We were told that as part of the action plan following the last visit, RMOs would be auditing T2/T3 forms on a weekly basis. We found that the review of these forms had not been completed as reported and will therefore repeat the recommendation from our last visit.

We raised this with the CNM and SCN on the day of the visit and requested an urgent review of the legal authority of treatment for all detained patients.

Recommendation 5:
Managers and responsible medical officers must ensure that all psychotropic medication is legally authorised and nursing and medical staff know where these T2 and T3 certificates can be accessed.

Recommendation 6:
Managers and responsible medical officers should review the audit system in place to ensure that all medication prescribed under the Mental Health Act is authorised appropriately.

Rights and restrictions

Melville Unit continued to operate a locked door, commensurate with the level of risk identified with the group of patients.

Of those that we met with, we found that they had a good understanding of their rights either as a detained or an informal patient. We were pleased to see the improvements the Melville Unit had made in relation to promoting rights and delivering rights-based care. From review of the care records we saw the use of the new canned text 'rights read' note that was used to ensure the young people were aware of their legal status and rights. We also found that the

patients' information board in the nurses' office had a reminder for staff to review rights with the young people. In addition to this, we found letters to the young people who were detained under the Mental Health Act, providing information on the order they were subject to and information on how to exercise their rights. From discussions with the young people, many of them had exercised their right to access legal representation and advocacy support.

Some of the young people we met with were subject to continuous intervention (CI). We found that for these young people, the CI was regularly reviewed by the MDT. We found comprehensive recording that included the purpose and requirement for CI, as well as what supports were offered to the young people during CI.

There was a seclusion room in Melville Unit. We were told that this room had never been used however, the area where it was situated was used recently for seclusion purposes. We were told during previous visits that the seclusion policy was in draft form. We asked the CNM and the SCN for an update on this policy and were told that the policy remained in draft form. The clinical services manager however told us later in the day that the seclusion policy had been authorised by senior managers, which was positive to hear, if seclusion was required in the future. However, we were concerned that this information had not been communicated to the ward staff, which again highlighted issues in relation to poor communication in the MDT.

When we are reviewing patients' files we looked for copies of advance statements. The term 'advance 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. We did not find any advance statements. Some of the young people we met with told us that they knew what an advance statement was and had made a choice not to complete one. Other patients did not have an understanding of advance statements. It was evident during review of the patient files and during discussion with some of the young people that they were not at a point in their recovery to be able to make decisions regarding their care and treatment. We were told by the SCN that for patients who are considering making an advance statement, advocacy is contacted to support the patient in this process.

The Melville Unit had a weekly community meeting. The meeting was run by members of the MDT with the purpose of offering a reflective space for young people to consider and discuss what was working well in the unit as well as any areas of improvement needed. The young people we spoke to provided positive feedback about the community meeting. A recent idea from the community meeting was the creation of a more 'child friendly' space in the communal area. We were told that the attendance at the meeting is dependent on the patient group however, the meeting was generally well attended.

We made contact with Advocard following the visit. We were told that Advocard staff attended the unit regularly and meet with young people who are an inpatient on a formal and informal basis. We were told that a fortnightly advocacy drop-in service was put in place when the Melville Unit opened however, advocacy staff found that this arrangement was not working well due to lack of access to suitable accommodation or staff not being aware that advocacy were attending the unit. It was agreed by Melville Unit management team and Advocard that the drop-in would be changed to monthly and this arrangement was working well. Advocard added that they requested information on advocacy services was added to the recently

reviewed admission information. We also heard that following the MWC visit, the SCN had requested advocacy input to staff training.

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

The activity in the Melville Unit was provided mainly by occupational therapy (OT) staff. Most of the young people in the unit either attended school in the morning or had been provided with school work to complete in the unit during school hours.

We met with OT staff who told us that Melville Unit launched an MDT meaningful activity and group programme in January 2023. We were told by OT that each young person was assessed on admission to the unit. The outcome of this assessment informed the young person's activity timetable with a focus on activities that were meaningful and in accordance with the young person's interests. Each young person had an activity care plan on TRAK and a copy of their timetable. We were pleased to see improvements to activity based support and how this was recorded and reviewed.

We saw and heard evidence of a range of activities in and out of the unit. At the start of each day, the young people were encouraged to participate in a 'seize the day' activity which provided an opportunity for young people to set a goal for the day and identify motivation to achieve their goal. Other activities included creative writing, flexible thinking, therapy pets, gardening group, art therapy and aromatherapy. We saw excellent examples of the creative writing some of the young people had produced in the form of the 'Melville News'. The newspaper article contained information about the ward, staff news and humorous stories as well as information about the Commission visit to the unit.

Art therapy was available on the ward on a weekly basis. We met with the art therapist who told us that art therapy groups were available to the young people one day a week. The art therapy group was located off the ward and was an 'open group' for young people to attend. Attendance was dependent on a risk assessment. The art therapy group was reviewed every six weeks to ensure the focus of the group continued to offer supportive time and space for the young people to create artwork and have an opportunity to talk.

The activity board listed some weekend activities, mainly young people using this time on a one-to-one basis with staff to engage in tasks out with the unit such as shopping. The SCN told us that every effort was made to protect time for staff to take young people out of the unit at the weekend when planned however, unfortunately due to staffing pressures, this could not always be facilitated. We heard that many of the young people spend increased periods of time with their families at the weekend. Young people told us that they had more 'down time' at the weekends and enjoy planned movie and pamper nights organised by staff.

We were told that activities were reviewed regularly using a 'you said, we did' board for feedback and suggestions. The young people we met with provided positive feedback regarding the structured groups, reporting that they found the groups enjoyable and beneficial.

The young people added that they would prefer more groups and structured activities, as there were long periods of the day that they did not have much to do and felt 'bored', especially young people who were unable to attend school. On review of the young people's files, we saw evidence of staff regularly offering young people the opportunity to engage in activities and the young people often refusing. Most of the relatives/carers we spoke to were happy with the level and choice of activity available in the unit.

The physical environment

The Melville Unit is located in The Royal Infirmary, Edinburgh. Most of the staff we spoke to raised that the location of the unit had become more problematic over the past year and especially since the change in the patient group. We heard from staff that after five o'clock in the evening, there was no additional support from mental health trained staff available. We heard that since the increase in acuity in the ward, there had been frequent reliance on hospital security staff and at times police to support with incidences of aggression. We were told that security staff had been trained in violence and aggression training however, support from mental health nursing staff would be very beneficial to the young people and staff during these situations.

The unit was bright and clean. We particularly liked the discharge tree painted on the wall at the entrance of the unit, with quotes from young people who had been discharged from the unit offering advice and hope to new admissions to the unit. This promoted a welcoming feeling to the unit.

All young people had their own individual bedrooms with en-suite facilities which were personalised with their belongings. There was a large communal area that had artwork on the walls completed by the young people. This supported a more homely and CAMHS friendly environment. There was a TV with Netflix in the communal area however, as reported by the young people, issues with access to Wi-Fi could be problematic.

The unit required some repair work. We were concerned to hear that many of doors in the unit were not secure doors and could be easily damaged by young people who were experiencing acute levels of stress and distress. On the day of the visit we saw doors that were damaged, some had glass panels boarded up resulting in staff having restricted observation of the young people, as well as reduced light in the unit. We were concerned to hear that there had been in excess of 60 reported incidents of damage to the doors in a six-month period. We were told by the CNM that these incidents had been escalated to senior managers and recorded on the risk register.

We commented in the previous two reports that review of the outdoor space was required due to issues with risk factors which was preventing the space being utilised to its full potential. We were told during the previous visit that funding had been secured from the climate fund to improve this area; unfortunately no changes had been made to the garden area. Many of the young people we spoke to told us that they felt the garden needed improvements made and they would like the opportunity to use this space more.

We were pleased to hear that funding had been granted to develop a sensory area in the ward. The CNM told us that this space will be used to create a therapeutic environment that young

people can use to support them to feel calm, relaxed and a safe space to regulate feelings. We were told that the room allocated for seclusion will be turned into a sensory space. We look forward to seeing the developments of this space during the next visit.

Recommendation 7:
Managers must address the outstanding environmental issues in relation to maintenance and the creation of a safe outdoor space for young people to use.

Any other comments

We noted there were high levels of staff involvement with young people either on a one-to-one basis or in group settings. The atmosphere on the ward was calm and welcoming. Staff that we spoke with knew the young people well. Although many members of the MDT raised concerns regarding a challenging working environment and low staff morale, staff appeared committed and motivated to support the young people. It was positive to note that the majority of young people and their relatives/carers we met with spoke highly of the care and support they received from the MDT.

The Commission are concerned that since the last visit, it would appear that cohesive and collaborative working in the MDT seemed to have deteriorated even further and continued to have a negative impact on patient care. The Commission raised concerns in the previous report that given the level of perceived disconnect between senior managers and staff who provide the care in the unit, it was not clear how these issues would be resolved. It was disconcerting to find during the visit that this disconnect was even more apparent. It appeared to us that attempts made by senior managers to resolve the interprofessional conflicts in the MDT had not been successful. There is therefore an urgent need for senior managers to develop a contingency plan that will enable all members of the MDT and new staff, to feel respected, valued and supported to ensure that safe and person-centred care is delivered to young people in the unit.

Summary of recommendations

Recommendation 1:
Managers should ensure nursing care plans are person centred, contain individualised information, reflect the care needs of each person and identify clear interventions and care goals.

Recommendation 2:
Managers should ensure care plan reviews are meaningful, include review of the effectiveness of interventions and reflect any changes in the individuals care needs.

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

Recommendation 4:
Managers must explore the current professional relationships between all disciplines in the MDT in order to identify interprofessional conflict, consider effective strategies to overcome this and promote effective and collaborative working, which should positively impact patient care.

Recommendation 5:
Managers and responsible medical officers must ensure that all psychotropic medication is legally authorised and nursing and medical staff know where these T2 and T3 certificates can be accessed.

Recommendation 6:
Managers and responsible medical officers should review the audit system in place to ensure that all medication prescribed under the Mental Health Act is authorised appropriately.

Recommendation 7:
Managers must address the outstanding environmental issues in relation to maintenance and the creation of a safe outdoor space for young people to use.

Good practice

We were pleased to see the improvements made to delivering rights-based care in the unit. All of the young people we spoke to were aware of their rights and we found evidence of them exercising their rights. The addition of the 'rights read' care record had supported and promoted awareness of rights.

Prior to the visit, the Commission were made aware of the transfer of a young person to the adult IPCU in the Royal Edinburgh Hospital for a period of intensive and individualised treatment and intervention. The Commission visited the young person on two occasions in IPCU and were pleased to see with the level and quality of support Melville Unit staff provided to the young person throughout the IPCU admission. It promoted consistency of care which was of benefit to the young person and their relative/carer. We heard that the addition of the patient co-ordinator role to the MDT has been positive in supporting transfers, admissions and discharges.

Service response to recommendations

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

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk

Mental Welfare Commission 2023