Mental Welfare Commission for Scotland

Report on announced visit to:

Ward 4, National Child Inpatient Unit, Royal Hospital for Children, 1345 Govan Road, Glasgow, G51 4TF

Date of visit: 23 April 2024

Where we visited

The National Child Inpatient Unit (NCIPU) is the nationally commissioned unit for children with significant mental health difficulties in Scotland. The ward provides six beds and admits children from all over Scotland who are aged between 5 and 12 years. We were told that there is some flexibility at either end of the age range, based on clinical need. On the day we visited, there were five children on the ward and one vacant bed; a few of the children were slightly older than 12 years. The service is located on the top floor of the Royal Hospital for Children building on the South Glasgow University campus.

We last visited this service in November 2022 on an announced visit and made no recommendations.

On the day of this visit, we wanted to hear about recent developments in the unit and the range of children it looks after. In recent years there had been some government proposals for redevelopment of the unit to enable a small number of children with intellectual disability to also be admitted there, however we understand that at present these plans are not progressing.

Who we met with

We met with, and reviewed the care of five children, one who we met with in person and four who we reviewed the care notes of. We also met with one relative.

We spoke with the senior charge nurse and the consultant psychiatrist.

Commission visitors

Dr Helen Dawson, medical officer

Kathleen Taylor, engagement and participation officer (carers)

Dr Mathew Beattie, ST6 higher trainee in psychiatry

What people told us and what we found

When we spoke with people who either were staying in the unit or had family members who were inpatients there, all were very positive about the caring and kind attitude of the staff looking after them. We were told that the children felt safe and cared for and felt confident and trusting when speaking with staff and sharing any concerns.
The unit had a friendly and calm atmosphere, and throughout our visit we saw multiple instances of child-centred practise which was personal to the group of children staying there at the time.

The parent we spoke to was very supportive of the staff and felt the care provided was highly tailored to the needs of the child and their families. We were told that the staff were very thoughtful and mindful of the pressures that parents were under while their child was ill and in hospital, and felt well informed and involved in their child's care.

Care, treatment, support and participation

Clinical records were located on NHS Greater Glasgow and Clyde's (NHS GGC) electronic information system (EMIS); we found EMIS to be easy to use and accessible with key information easily found. The clinical records were of a very high standard with detailed, child-centred care plans that addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the child.

The treatment goals of the care plans were clearly described and we could see evidence of regular reviews, with progress towards each goal taking place regularly. The use of easy read versions of the care plans and pass plans were provided for each child, and were well established in the unit, ensuring that children were supported to be involved in their care in a meaningful way.

In the weekly multidisciplinary meetings, we saw substantial evidence of the views of children and their families being sought and considered as part of decision-making and the standard of communication between the clinical team and the child, their family and other professionals appeared robust. During our visit, we learned that speech and language therapy (SaLT) have been involved in training a number of staff in ways to support communication with the use of visual aids. We could see evidence of this practise throughout the unit and recorded in the children's clinical notes, in guidance and leaflets that were available, and with visual aids and timetables on the walls.

Multidisciplinary team (MDT)

The unit has a multidisciplinary team (MDT) on site consists of a psychiatrist, nursing staff, occupational therapy, physiotherapy and speech and language therapy staff, systemic and family therapy staff and psychology staff. We were told that currently there were no nursing vacancies and a vacancy for a consultant psychiatrist. This broad range of disciplines are either based in the unit or accessible to it.

It was clear from the very detailed MDT meeting notes that everyone involved in an individual's care and treatment is invited to attend the meetings and give an update on their views. Every four weeks, meetings are arranged to also include the child's family and/or carers and also the child's community Child and Adolescent Mental Health Service (CAMHS). It was clear to

see from these notes that when a child is moving towards discharge that community services are extensively involved in preparatory meetings. After each MDT meeting, the unit's care manager has a key role to support communication to update a child's family and/or carers, as well as the community CAMHS service, with information from the meeting.

We heard that the regular unit meetings continue to be held on line in order to support attendance by people located all across the country. We were assured that family members wishing to attend, but who were not keen on using the online facility, continue to be given the opportunity to attend any meetings in person.

Use of mental health and incapacity legislation

On the day of our visit, a number of those in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

All documentation relating to the Mental Health Act, including certificates around capacity to consent to treatment, were in place on EMIS and were up-to-date.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. We found that consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required, were up-to-date and corresponded to the medication that was prescribed.

We shared with the service an electronic aide that we had seen locally, which had been developed by another service in NHS GGC, when they were making adaptations to HEPMA, the electronic medication prescribing system. This aide allowed a 'pop up' of a child's T2 or T3 form (when relevant) to occur whenever their prescription record was accessed. This supported anyone prescribing for the child, or dispensing medication, to be able to cross check quickly that the medication being prescribed/dispensed was legally authorised. The unit were keen to explore whether this was something they would find helpful.

Recommendation 1:
The clinical team should continue to explore adaptations to HEPMA to enable an electronic copy of any T2 or T3 to be available at all times to anyone either prescribing medication or dispensing medication and so ensure that authority for treatment is easily verifiable.

Rights and restrictions

The ward had a number of areas that were locked and prevented entry into, and egress from, the ward without appropriate permission. Staff told us they felt the correct balance had been achieved internally between doors that provided the necessary barriers to limit access, and doors that created an unnecessary obstacle to appropriate movement.

Activity and occupation

The unit has a number of rooms available for different sorts of recreation and a room in which a number of children can watch television together. There is an indoor soft play and sensory room which are well equipped and valuable resources when the children are unable to go outside.

We were not able to see these rooms on the day of our visit, nor gain access to the rooftop garden due to their use by one of the children relating to their clinical needs. An art room was available and there was a lot of evidence of the children making use of this facility. We saw a film made by one of the children with the help of staff which was one of a number of examples of the clinical team's commitment and flexibility to collaborate with the children and build on the strengths and interests of the children who stay there.

On the ground level adjacent to the hospital building there is an outdoor play park which the children can access with ward staff or with their families or carers. As with our previous visits, this year we again saw the unit continue to support the appropriate use of exercise, with care plans for some children and guidance for parents developed by the ward's physiotherapist. The patients in the unit access school facilities and activities relating to education form an important aspect of most children's daily timetables.

The physical environment

The ward is located on the top floor of the hospital and is shaped in an arc with all rooms, including children's bedrooms, off to one side and many glass windows looking out onto a roof cupola on the other. During our visit, the ward appeared bright and airy, clean and well decorated. The entrance to the unit has a reception area, with noticeboards providing factual information about the ward, and suggestions for families about places to go in the nearby area. We were told that the families of children who come from other parts of the country, and do not know the area well, find this practical information very helpful.

The ward has continued to develop resources for children and their families on a range of topics, and have made use of technological advances to increase the accessibility of this information. We were impressed by the work that has been undertaken, which continues to be developed. In the future, it may be helpful for the unit to consider guidance about people's right for a carer's assessment, and which could provide a helpful opportunity for sharing information with the children's families.

In the unit itself, the communal wall space is used creatively to support individual patients' care, with timetables for the day in easy read format that are attractively decorated, and versions displayed on the walls to help orientate and act as a reference point for both children and staff throughout the day.

Many of the unit's walls carry a range of artworks developed by the children who are currently inpatients. These were attractive, personalised and well considered; they helped to serve as a footprint for the children in supporting their connection to the ward environment. The communal wall artworks are refreshed regularly to reflect the turnover of patients in the unit and to try and ensure that all children who are currently inpatients are provided with the opportunity to collaboratively decorate the unit's walls.

A number of the children's rooms are en-suite and the bedrooms we saw appeared well lit, clean and tidy. Again all rooms were personalised to reflect the interests and preferences of the child and many had materials on the wall, reflective of and supportive of particular treatment goals for the child.

Summary of recommendations

Recommendation 1:
The clinical team should continue to explore adaptations to HEPMA to enable an electronic copy of any T2 or T3 to be available at all times to anyone either prescribing medication or dispensing medication and so ensure that authority for treatment is easily verifiable.

Good practice

We recognise the embedded nature of person-centred practise in the unit and the established practise of ensuring that children's views about their care are considered and valued. The clinical teams use of visual supports to help communication throughout the ward was impressive and the use of technological innovations to develop guidance about a range of relevant topics for children and their families was highly valued.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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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