Mental Welfare Commission for Scotland

Report on unannounced visit to:

The Melville Young People’s Mental Health Unit, Royal Hospital for Children and Young People, 50 Little France Crescent, Edinburgh, EH16 4TJ

Date of visit: 4 July 2024

Where we visited

The Melville unit at the Royal Hospital for Children and Young People (RHCYP) is a 12-bedded specialist Tier 4 inpatient service, designed for children and young people with mental ill health, aged 12 to 17 years (inclusive). On the day of our visit, there were 11 young people on the unit. Beds in the unit are primarily intended for children and young people from the Lothian region, although there are specific agreements in place for individuals 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 September 2023 and made seven recommendations in relation to care planning, the multidisciplinary team exploring increased participation of all keys disciplines, ways to promote effective and collaborative working, responsible medical officers (RMOs) ensuring all psychotropic medication is legally authorised and outstanding environmental issues addressed.

When reviewing the action plan provided by the service for the recommendations in 2023, we were concerned that the response which detailed actions for improvement had not progressed to the extent that the Commission would have expected and in some areas, there had been no progress at all.

We also noted that some of the recommendations had been set out in previous visits, specifically those in relation to care planning, communication, rights-based care, inter-professional conflict in the multidisciplinary team (MDT), treatment not being legally authorised and environmental issues.

On the day of the visit, we wanted to meet with the young people, family/relatives, staff and hear their views and experiences of how care and treatment was being provided on the unit.

We also wanted to have a follow up meeting after our visit with senior managers; a feedback session took place soon after the visit to Melville Unit where we discussed our findings and had the opportunity to hear about the challenges the service continued to experience, and some of the proposed changes that the service was considering.

Who we met with

We met with, and reviewed the care of seven people, two who we met with in person, and we reviewed the care notes of all seven. We also met with, or spoke with, four of the young people's relatives/carers.

On the day of the visit, we spoke with the senior charge nurse (SCN), the senior nurses, nursing staff, a consultant psychiatrist, an occupational therapist (OT), a social worker, and the art psychotherapist.

We also made contact with advocacy service, Advocard.

Commission visitors

Kathleen Liddell, social work officer

Lesley Paterson, senior manager, practitioners

Claire Lamza, executive director (nursing)

Arun Chopra, executive director (medical)

What people told us and what we found

Comments from the young people

We met with two young people, and the feedback was mixed. We heard from them that most staff were “nice” and “supportive”. They said they valued one-to-one time with their key nurse however, reported that this did not happen as much as they would like.

We heard from staff that the unit had staff shortages, and that bank and agency staff were used regularly. The young people told us that they did not always feel safe when unfamiliar staff were on shift, as they did not feel these staff had a good awareness of their care and treatment needs. We heard from one young person that they had not agreed with physical observations being taken when planned. As a result of this, the observations were not taken, and there was limited information available to inform decisions about the young person’s care planning, specifically their pass plan. The impact that this had on them was that they were unable to spend time out of the ward and this caused them to be “extremely upset”.

Another young person told us that while being on continuous observation, the member of bank staff who was due to be observing them ‘fell asleep’, which did not make the young person feel safe and supported. The young people that we spoke with told us they preferred working with permanent staff who were based in the unit, as they had the necessary specialist skills and knowledge needed to deliver their care.

We also heard that a few days prior to the Commission’s visit, there was a day when the patients in the unit did not receive an evening meal. The young people we spoke with thought this was due to ‘a crisis’ in the unit at the time. We were told by the young people that they felt “agitated” and “scared” and for some, they were concerned about the negative impact on their care plan. We raised these concerns with the SCN on the day of the visit and were advised that bank and agency staff were required to support the complex needs of the young people in the unit. The SCN was aware of the issues raised by the young people and advised that it was hoped the introduction of new, permanent staff in the coming months would resolve some of these issues.

We again heard mixed views about the young person’s involvement and participation in discussions and decisions about their care and treatment. The young people told us that they were invited to attend the weekly MDT meetings which they found positive however, at times felt their views were not fully taken on board. We heard that not all agreed decisions made at the MDT meetings were progressed, an example being decisions regarding discharge and pass, which caused the young person distress and upset. One young person felt that it would be useful to have

some one-to-one time with a member of the nursing staff after the MDT meeting to chat through decisions made. However, we heard that nursing staff did not always attend the MDT meeting, so were unaware of decisions made.

Those young people we spoke with were not fully aware of their care plan. One young person said they had been given a weekly timetable but had not been involved in discussions about this, or about their care plan; they did not think that the timetable was personalised to their care and treatment goals. One young person told us about their concerns over discharge planning. They were due to move to an adult inpatient mental health service in the near future, and they had been told the transition to this ward would be supported, however, this was now not happening. They told us that this was causing them a great deal of worry and upset.

The young people we spoke with raised that there were long periods of the day when there was not much to do in the unit, resulting in them spending long periods of time feeling "bored" and opting to spend time alone in their room. One young person told us that although they felt anxious about participating in a planned group activity, they had agreed to do so, and when the group did not run, with no communication from staff as to why the group did not take place, they were left disappointed.

We were pleased to hear that a previous issue we had noted in our last visit, about the Wi-Fi connection, had improved which supported young people being able to access electronic devices, which they enjoyed.

Those that we spoke with had a mixed awareness of their rights in relation to their detained and informal status. One young person was unaware of advocacy services and felt that this service would be of benefit to them. We discussed this with the SCN who advised that advocacy services were available on referral.

The young people told us that the environment could be "challenging" at times and described witnessing and feeling frightened when there were incidents of aggression from other young people in the unit. We heard that when there was 'a crisis' in the unit, the young people tended to go into their room to avoid the situation. We also heard that there was a lot of damage to the doors and furniture in the unit, which did not make the environment feel homely or safe.

Comments from relatives/carers

We also heard mixed views from the relatives/carers that we spoke with. Some told us that they felt staff were "very welcoming" and the majority of the care and treatment their child received was "good" and they were supportive of the admission.

We did hear from some relatives/carers that they felt frustrated that there was insufficient community CAMHS services available; they told us that if there had been increased community support, this could have prevented admission. We heard from

some about their experiences of a difficult admission process due to a lack of staff, poor communication and poor information being provided during the admission process. Those that we spoke with said that it would be helpful for relatives/carers if staff introduced themselves and provided information about their role when their child was admitted.

We were pleased to hear from the relatives/carers that the welcome pack that is now provided by the unit was positive. They told us that it would be even better if staff could make time to read through this information with the young people and family, and that this would help to alleviate some anxieties about being in the unit.

The relatives/carers told us that they could see the detrimental impact of when the unit was short staffed, and how this affected staff's ability to provide the necessary care and treatment to their child. Relatives/carers raised concerns about the level of bank and agency staff used in Melville Unit. The relatives/carers made a similar comment to one made by the young people we spoke with, in that they felt more confident when permanent staff, and in particular the key worker, were on shift; they noted that there was better communication and care in these circumstances.

We were advised by some relatives/carers of their concerns about the risk of harm to their child while being in the unit, with most of them making us aware that there were occasions when they left the unit and felt "worried" about the safety of their child. We heard that relatives/carers had raised their concerns with the senior managers team, and one relative said that they had to "fight for everything" for their child. We heard from relatives/carers that they either had raised or were going to raise their concerns formally.

All of the relatives/carers that we spoke with reported that the communication in the unit amongst the MDT was mostly poor. Similarly to the views of the young people we spoke to, we heard from the relatives/carers that particularly for nursing staff, who were not always aware of the agreed plans, this created a lack of trust for the relatives/carers.

More positively, for those relatives/carers who were aware of the parents' support group that took place weekly in the unit, and who had attended this, they found that the group had been beneficial in providing support and information.

And for the relatives/carers that we spoke with who had attended the MDT meetings, they told us that they had found these meetings to be mostly positive; the MDT meeting had provided an opportunity for them to give their views and vital information that would support their child's care plan. There were some relatives/carers who told us that they did not find that the agreed decisions made at the meeting had been progressed and actioned as they expected. We heard that changes to care, the transition point from children to adult services, and particularly

in relation to discharge planning, were made outwith the MDT meeting. These decisions were then not communicated to the families. We heard this caused “distress” and “fear” for parents and their child, especially with transitions. We heard that discharge was daunting enough, but when there was a lack of a transition or discharge plan, this only compounded the relatives’/carers’ worries and anxiety.

Care, treatment, support and participation

Nursing care plans are a tool which identify detailed plans of nursing care; they ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

The Commission has, in our previous reports, made recommendations about nursing care plans, reviews and the audit of the care plans. These recommendations reflected a lack of evidence of person-centred and personalised information and the need for nursing care plans to reflect the care needs of each young person and identify clear interventions and care goals.

We once again reviewed the care plans which were stored electronically on TRAKcare and found no improvement to nursing care plans since our previous visit. The nursing care plans reviewed were mainly prescriptive, with little evidence of person-centred, personalised information or the necessary detail on the purpose of the nursing intervention; in one case, we found that the young person did not have a care plan. We raised our concerns with the SCN and the RMO, advising them that we would expect a nursing care plan to be completed to support the care and treatment of all young people receiving care provided the team in the Melville Unit.

We were unable to find consistent and robust discharge planning arrangements. We were told that the unit held early care planning meetings in which discharge planning was discussed, but we could not find this in the files we reviewed. We heard, and saw, that discharge was discussed at weekly MDT meetings however, we were concerned that the agreed decisions did not always progress as planned. Through discussion with various members of the MDT, we were told that there were a variety of factors that had an impact on discharge.

We heard that discharge planning for many young people was complex and that there was a lack of adequate community supports to facilitate the discharge. We were advised that the demand for beds could impact on discharge planning and at times, decisions could result in ‘premature’ and ‘failed’ discharges. When discussing this with staff, they reported that discharge planning could be improved if inpatient and community teams worked together on the agreed action points and in progressing them.

We did not find evidence of the participation of the young person in the care plan process. Some young people were unaware they had a care plan and told us that

they did not feel involved in decision-making regarding their care and treatment. The principle of participation is set out in the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act); individuals should be fully involved in all aspects of their assessment, care, treatment, and support. We were concerned that the service has been unable to evidence their responsibility in meeting this principle.

Recommendation 1:
Managers must 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 the young person's participation.

And while we were pleased to see the involvement of relatives/carers in some care plans, this was not consistent. We were unable to clearly see from the records whether relatives/carers had been asked about and invited to become involved.

When reviewing the nursing care plans, we were unable to locate reviews that included a summative evaluation of intervention(s), of the targeted nursing intervention or the individuals' progress. In our previous report, we made a recommendation in relation to the poor quality and inconsistent review of the nursing care plans; contrary to the service response that this had been actioned, we found no improvement in the care plans we reviewed.

Recommendation 2:
Managers must ensure care plans are regularly reviewed to ensure they record information on the effectiveness of the intervention.

The risk assessments we reviewed were of mixed quality. We found that for some, the risk assessments were comprehensive and of a high standard, the risk was clearly recorded, with a plan to manage the identified risk. We reviewed other risk assessments that did not have the level of detail required in relation to the identified risks, triggers, protective factors, and risk management plan. We were concerned that the risks recorded in the care records were not reflected in the risk assessment. We discussed this with the SCN on the day of the visit and were told that risk assessments were not reviewed as regularly as required due to staffing challenges.

We discussed the variable quality of the care plans and reviews with the SCN on the day of the visit. We were told that clinical educators had provided staff training on care planning since the last Commission visit. The SCN added that ongoing improvements to care planning and the review of care plans was required however, due to staffing pressures, it was difficult to regularly audit care plans and offer additional support and time to nursing staff to complete this task.

In our previous visits to the Melville Unit, we have been advised that information technology (IT) in NHS Lothian have been developing a care plan template specifically for CAMHS. At the time of this visit, there has been no further progress

with this, and we heard 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.

Care records

During our visit, we looked at the young people's information that was held electronically on the IT system, TRAKCare.

The care records identified that there were high levels of mental health acuity in the Melville Unit. The records noted that young people in the unit could experience significant stress and distress, leading to increased clinical risk related to self-injury, verbal and physical aggression. It was positive to note that the MDT were actively involved in providing support, care and treatment to the young person during times such as these.

While we found that the majority of care records were comprehensive, person-centred and provided information on how the young person had spent their day, some lacked this level of detail and mainly focussed on personal care interventions. This made it difficult to see how the young person had presented throughout the day and what therapeutic interventions the young people had engaged in.

There were some good examples of strengths-based approaches in care records entries recorded by various members of the MDT, specifically the responsible medical officers (RMOs), the associate physician and medical staff. We were pleased to find the information recorded by the occupational therapist (OT) and art psychotherapist was comprehensive, individualised, goal focussed, person-centred, and adopted a strengths-based approach. We found that these care records included the views of the young person and relative/carer where appropriate, along with a professional assessment and an action plan.

We saw that most of the young people had one-to-one nursing interventions and were subject to continuous intervention (CI). We found that there had been a reduction in therapeutic one-to-one interventions between the young people and nursing staff since our previous visit; we were told this was due to staff responding to crisis interventions that occurred more frequently; the young people and their relatives/cares had also advised us of this. We did find evidence of one-to-one interactions between young people and other members of the MDT, specifically OT, psychology, and the associate physician.

We were pleased to see that physical health care needs were being addressed and followed up appropriately by the associate physician and medical staff.

Multidisciplinary team (MDT)
Care and treatment in the Melville Unit is provided by the MDT and consists of one full- and one part-time consultant psychiatrist, nursing staff, psychology assistants, an associate physician, dieticians, family therapy, art psychotherapy, education, and social work. We heard that the consultant psychologist post had remained vacant over the past year, although the post has gone out to advert.

We found comprehensive and detailed recording of the weekly MDT meeting including discussions, decisions and future planning that took place, and evidence of where young people and relatives/carers were invited to attend.

We continue to be concerned to hear and see that nursing staff's attendance at the MDT meetings remains inconsistent; we have raised this in previous visit reports. All disciplines that we spoke with were of the view that the attendance of nursing staff at the meetings was considered to be vital, and this was supported by the MDT. We discussed this with the SCN on the day of the visit and advised them that we remained concerned that without the consistent attendance of nursing staff at the MDT meeting, a fully collaborative and holistic approach to the care delivery on the unit could not take place.

Recommendation 3:
Managers must put in place measures to ensure all key disciplines involved in care and treatment delivery are present at every MDT meeting, to support and promote collaborative working, shared decision making and information sharing.

We were pleased to hear that work had been done to address previously highlighted concerns around interprofessional conflict and that some improvements had been made. We spoke with various members of the MDT who agreed that efforts had been made although ongoing work was needed to support a shared MDT approach and collective way of working.

Since the previous Commission visit, five newly qualified nursing staff have started in the unit, with the new staff being enthusiastic and willing to learn, which has improved staff morale. We were pleased to hear of the programme that provided support for all newly qualified staff to develop their skills and knowledge. We did not speak with any newly qualified staff on the day of the visit however, the SCN told us that all who had been recruited have stayed on in Melville Unit, and that feedback regarding the additional support provided to all new staff has been positive.

We were told that a further eight newly qualified nursing staff have been recruited and will start in the unit in September 2024. Until this time, bank and agency staff are being used to provide essential staff cover. On the day of the visit, we saw that a number of bank staff were being used on the day, and it was mostly non-permanent staff that we spoke with. While the addition of new staff is to be welcomed, we heard

that many experienced staff who have worked with children and young people in this type of setting have moved on from the unit and as a result of this, the team is not as well balanced in terms of skill and expertise. Those that we spoke with told us that the unit could be a challenging environment to work in, and that more permanent staff, with the experience needed to meet the complex needs of young people was needed. We were advised that the vacant consultant psychology post had, in part contributed to difficulties in the unit and MDT. It was hoped that when this position is filled, there would be an opportunity to review clinical pathways, MDT formulations and offer more reflective opportunities for the MDT.

We were encouraged to hear that staff continue to get enjoyment from their role and remained committed to providing good quality care and support to the young people they work with. Staff we spoke with said that they would like more time to engage in therapeutic intervention with young people, rather than providing crisis interventions on a continuous basis, as this would support the development of a more therapeutic relationship.

We were pleased to hear about the actions taken by the senior management team to support staff, that now included a weekly team meeting with continuous professional development (CPD) incorporated.

Use of mental health and incapacity legislation

On the day of our visit, eight young people were detained under the Mental Health Act. We found the forms relating to each detention stored electronically on TrakCare.

Part 16 (sections 235-248) 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 prescribed medication for all young people in the unit, 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. We have found on our visits in NHS Lothian that navigating both electronic systems simultaneously can be a practical challenge. We have also commented when on other visits to NHS Lothian services that being paper-lite is potentially problematic, as it can reduce the ease of checking that the

correct legal authority is in place when prescribing or dispensing treatment for those who are detained. For this reason, and as suggested during our previous visits, a paper copy of all T2 and T3 certificates should 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 were disappointed to see that limited progress had been made with this suggestion.

On cross-checking the electronic records for each young person, we found that six young people were prescribed treatment that was not authorised on a T2 or T3 certificate, when these were required, and this medication had been dispensed without the legal authority in place to do so. We also noted that in some cases, DMP requests had been submitted late, which increased the likelihood of the appropriate authorisation not being in place at the point where it was required.

We have previously made recommendations in relation to legal authority to treat the young people. We heard that one of the RMOs was using an excel spreadsheet to alert the team to the timing of when mental health act paperwork, including authority to treat aspects required to be completed. While this was welcomed, it did not support the improvements required to ensure all psychotropic medication was legally authorised.

Recommendation 4:
Managers and responsible medical officers must ensure that all psychotropic medication is legally authorised and nursing and medical staff know where these certificates can be accessed at times of prescribing and dispensing.

Input from pharmacy, may also have supported prescribing practices; it is suggested that it would be helpful to consider specialist children and young people mental health pharmacist input due to the age, acuity and degree of illness of the individuals on the unit, the complexity of medication use, and the specialist nature of treatments being provided.

Recommendation 5:
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.

We are necessarily repeating our previous recommendations in relation to legally authorising treatments and the audit of these as we remain concerned.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found documentation recorded on TRAKCare and this was easily located.

Rights and restrictions

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

Of the young people we met with, we found that they had a mixed understanding of their rights, either as a detained or informal patient. We found letters to the young people who were detained under the Mental Health Act that provided information on the order they were subject to and information on how to exercise their rights. We were pleased to see the improvements made by Melville Unit in relation to promoting rights and delivering rights-based care. These improvements were supported by the introduction of a canned text 'rights read' note that was used to ensure the young people were aware of their legal status and rights, however on this visit, we found that there had been a reduction in the use of the 'rights read' canned text in the care records we reviewed.

We also looked for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 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. None of the young people met with had an advance statement and from review of the care records, we did not find any advance statements. In our review of the care records, and during discussion with some of the young people, we found 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 young people who were considering making an advance statement, advocacy was contacted to support 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.

When reviewing care records, we saw that a number of the young people were subject to continuous intervention (CI). We were concerned to read, and hear that for some of the young people, this intervention had not prevented harm occurring. We saw that a Datix report (system used by NHS staff to report incidents and risks) and an MDT review had been completed following these incidents. We did not find that the incidents had been raised in line with local Child Protection procedures or referred under Adult Support and Protection (Scotland) Act 2007 (ASP Act) for young people aged 16 years and over.

Where harm/risk of harm is identified against a child, all NHS staff have a duty of care and must take action in line with local child protection procedures. For young people aged 16 years and over, NHS staff have a legal duty under Section 5 of ASP

Act to report harm to the local authority for the area in which the young person is located.

Recommendation 6:
Managers must ensure that where harm is identified in the unit, safeguarding legislations and policies are followed to ensure there is an MDT forum to discuss the harm and make decisions and safety planning.

Sections 281 to 286 of the Mental Health Act provide 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 this and where restrictions are introduced, it is important that the principle of least restriction is applied. Two young people were specified on the day of the visit. Where these restrictions were in place under the Mental Health Act, we found incomplete documentation and highlighted this to the SCN on the day of the visit.

The Commission has published specified persons good practice guidance.

Recommendation 7:
Managers must ensure that all restrictions being placed on young people in the unit are legally authorised under specified person legislation and proper notification has been given.

We made contact with the local advocacy service, Advocard following the visit. We were told that Advocard had a link worker for the Melville Unit who attended when a young person was referred for advocacy support. During our previous visit, Advocard provided a monthly advocacy drop-in service in the unit. We heard that the drop-in service had ended due to a number of factors. Advocard told us that when they attended the unit for the drop-in service, staff were often unaware they were attending and there was no space available to use. The drop-in was not well used by the young people, which may have been linked to a lack of advertising or awareness on the unit.

Advocard also reported that that they had had additional funding specifically for young people who use child and adolescent mental health services (CAMHS). However, the additional funding had not been continued therefore Advocard had fewer staff available to attend the Melville Unit.

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.

Activity and occupation

The activity in the Melville Unit was provided mainly by OT staff. Edinburgh Children's Hospital Charity also provided activities in the unit. The young people were on school

summer holidays on the day of the visit. We heard that the young people in the unit either attended school during term time or had schoolwork provided to complete in the unit during school hours.

From the feedback of the young people and relatives/carers that we spoke with, there was a view that there was a lack of planned and structured activity in the unit. Young people reported long periods of time where they felt “bored”. On the day of the visit, we saw that there was a planned activity, and the Commission visitors attended as advertised along with some of the young people. However, the activity did not go ahead at the time advertised, and unit staff were unable to provide any information. The activity did take place an hour later than advertised and reflected what the young people and relatives/carers told us about changes and cancellations of planned activities. We raised this with the SCN and highlighted the importance of activities taking place as planned and if they are unable to, this information must be communicated to the young people.

We met with an OT who told us that each young person’s care and support needs were 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. We were told that each young person had an activity care plan on TRAKCare and a copy of their timetable. On review of the care files, we did not see an activity plan for all young people. The young people we met with had a copy of their timetable but were unaware of their activity care plan. We were unable to find evidence of regular activity recorded in care records reviewed. We discussed this with the OT who advised that many young people declined to engage in activities, however, were offered activities daily. We asked if the young person’s decision not to engage in activity was recorded and were advised staff did not regularly record if a young person had declined an activity. We highlighted that by not recording that the young person had declined to engage, it suggested that young people were not being supported to engage in planned activities recorded on their weekly timetable.

Recommendation 8:
Managers should ensure that all activity is offered in line with each young person’s activity planner and that their decisions to participate or not are recorded.

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 a creative group, ‘Try it out Tuesday’, games group, therapets and aromatherapy. We heard that the unit had new therapy dogs which the young people enjoyed.

We were told by the OT that activities were regularly reviewed with young people during the community meeting and that they were encouraged to use the ‘you said, we did’ board for feedback and suggestions.

We met with the art psychotherapist who told us that since the last Commission visit, art therapy groups had ended, and one-to-one art psychotherapy was being offered. We heard that two young people were being offered one-to-one art psychotherapy, as agreed by the MDT. We reviewed the care record of one of the young people engaging in art psychotherapy and found there was a comprehensive care plan of the aims and objectives of the intervention and how it would be delivered. We were impressed with the quality of the recording of the one-to-one art psychotherapy sessions which were comprehensive, strengths-based, included the young person’s views of the intervention and a plan for the next session.

The physical environment

The Melville Unit is located in the RHCYP. We made a recommendation in the previous report in relation to outstanding environmental issues. Little progress of the condition of the environment has been made. We saw and heard about the outstanding repair work required in the unit, most notably, the doors at the entrance and throughout the unit. Many of the doors had broken glass panels which were boarded up; this did not promote the feeling of being welcomed to the unit.

We heard that there was regular damage to the unit caused by young people experiencing acute levels of stress and distress. Staff we spoke with commented that they did not think the current environment provided the level of security required for the complex needs of this group of young people who required inpatient care and treatment. We were told by the SCN that these incidents had been escalated to senior managers and had been recorded on the risk register.

Otherwise, the unit was bright and clean. 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 some artwork on the walls completed by the young people. There was a TV with Netflix in the communal area.

We found the ward environment busy and at times, chaotic on the day of the visit. We appreciate the visit was unannounced which may have caused some anxiety/stress to the young people and staff. Nevertheless, we found the environment to be less homely, therapeutic and not a CAMHS friendly environment. We were told during the last visit that funding had been granted to develop a sensory area in the unit that would be used to create a calm and relaxed space in the unit, but this had not happened.

Some staff were of the view that due to the complexities of the needs of the young people and increased risk, the environment had been changed/adjusted to manage

risk as a priority, resulting in more stark/bare aesthetic. There was a view from the staff that the environment could have a negative impact when supporting and meeting the treatment goals of the young people. We heard that a move towards developing a more therapeutic environment was required to support staff to deliver therapeutic activity and intervention.

In our previous reports we had reviewed the outdoor space, noting that the space was not being utilised to its full potential. We were disappointed to find no changes had been made to the garden area and the same issues in relation to a lack of safe outdoor space remained a concern. We repeat our previous recommendation in relation to the environmental issues.

Recommendation 9:
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
This is the Commission's fourth visit since April 2022. 23 recommendations were made during the previous visits. It is of significant concern that many of the same recommendations were made again during this visit thereby evidencing little improvement action taken to date.

When the Commission visits, we ask for a SMART action plan to be provided which evidences the action being taken to address recommendations made. To date, the SMART actions plans we have received in relation to our recommendations to Melville Unit have not provided this assurance, nor have they had the impact that we would have expected as noted above.

Because of these concerns, along with the lack of improvement after four visits and 32 recommendations, the Commission met with all key staff including the heads of service, general and senior managers, and clinical staff from the Melville Unit. We highlighted our significant concerns about the unit and wanted to hear about any plans that NHS Lothian may have been considering for Melville.

We will formally write with our concerns to the heads of service who have operational and strategic responsibilities and will continue to liaise with senior managers and clinical staff for the Melville Unit to ensure that action is taken.

Summary of recommendations

Recommendation 1:
Managers must 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 the young person's participation.

Recommendation 2:
Managers must ensure care plans are regularly reviewed to ensure they record information on the effectiveness of the intervention.

Recommendation 3:
Managers must put in place measures to ensure all key disciplines involved in care and treatment delivery are present at every MDT meeting, to support and promote collaborative working, shared decision making and information sharing.

Recommendation 4:
Managers and responsible medical officers must ensure that all psychotropic medication is legally authorised and nursing and medical staff know where these certificates can be accessed at times of prescribing and dispensing.

Recommendation 5:
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 6:
Managers must ensure that where harm is identified in the unit, safeguarding legislations and policies are followed to ensure there is an MDT forum to discuss the harm and make decisions and safety planning.

Recommendation 7:
Managers must ensure that all restrictions being placed on young people in the unit are legally authorised under specified person legislation and proper notification has been given.

Recommendation 8:
Managers should ensure that all activity is offered in line with each young person's activity planner and that their decisions to participate or not is recorded.

Recommendation 9:
Managers must address the outstanding environmental issues in relation to maintenance and the creation of a safe outdoor space for young people to use.

Service response to recommendations

The Commission requires a response to these recommendations 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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