

Mental Welfare Commission for Scotland

Report on announced visit to: Royal Edinburgh Hospital,
CAMHS Inpatient Unit, Tipperlinn Road, Edinburgh EH10 5HF

Date of visit: 7 July 2016

Where we visited

The Child and Adolescent Mental Health Service (CAMHS) Inpatient unit has 12 inpatient places for adolescents with mental health problems. It is a specialist tier 4 service designed for young people aged 12 to 17 years (inclusive). The beds are primarily intended for Lothian patients, with specific agreements to take patients from Fife and Scottish Borders. There is also a more general agreement to take patients from other Scottish health boards on an emergency basis.

In addition to the main CAMHS inpatient service there is an additional unit used to provide inpatient care, when required for one young person with learning disability. This is situated adjacent to the main CAMHS building and is staffed by the CAMHS Learning Disability Intensive Community Support Service.

We last visited this service on 29 April 2015 and made recommendations in regard to staffing levels, care plans, care files and activities.

On the day of this visit we wanted to follow up on the previous recommendations and also look at the use of mobile phones and safekeeping of personal property. This is because concerns regarding these issues had been brought to the attention of the Commission by the Patient's Council and relatives of patients.

Who we met with

We met with and or reviewed the care and treatment of six patients. We met with relatives of two current inpatients and one patient who was very recently discharged.

We spoke with the interim chief nurse, the senior charge nurse and the clinical lead for the service as well as several of the nursing staff on duty.

Commission visitors

Margo Fyfe, Nursing Officer

Mike Warwick, Medical Officer

Kathleen Taylor, Engagement & Participation Officer (Carer)

What people told us and what we found

Care, treatment, support and participation

Staffing

At the time of the last Commission visit to the unit there had been pressure on nursing staff due to several factors including the high level of care required by the patient group and some staff sickness. This had lowered staff morale as they felt they struggled to meet all the patient care needs at that time. We were also aware that the consultant medical cover for the unit had been on a locum basis for some time.

We were pleased to hear that this issue has been thoroughly discussed by managers and steps have been taken to increase the nursing staff in the unit whilst adopting a rotational pattern of working between tier 4 treatment level nursing staff in the NHS Lothian CAMH Service. This ensures there are always experienced staff on shift in the unit working alongside the new, less experienced staff. We were also pleased to note that there are two activity co-ordinators who provide activity both on and off the ward for individuals and small groups.

It was also good to hear that the current locum psychiatrist is supportive of staff and works well within the team. He is expected to remain until the full time consultant psychiatrist comes back to his post in the autumn.

We look forward to seeing the progress of the staffing changes at future visits.

Care Plans

Unfortunately as at the time of our previous visit we found the care plans were brief and focussed on essential care e.g. meal plan, post meal support. Although on this occasion we saw one care plan that encompassed stressed and distressed behaviour the interventions described lacked detail. We found the care plan evaluation sheets only contained the date of review but no summary or evaluation. We are concerned at the lack of clear information in care plans and that there is no direct correlation between the care plan and the weekly multidisciplinary (MDT) review meetings.

MDT input and review

We heard that there is good multidisciplinary input in addition to nursing staff and the consultant psychiatrist, including a specialty doctor, psychology, occupational therapy, dieticians, physiotherapist, family therapist and education staff.

Young people can attend their weekly MDT review meetings, and are encouraged to complete sheets with feedback and issues that they would like to discuss. Parents can also attend, and parents we spoke to told us that they do. It is good to see that

there is a high level of participation of individuals in these meetings. We also noted that the minute from these meetings is typed up and given to the young person and their parents as well as included in the care file.

MDT records

Professionals from different disciplines write in the same MDT records. We appreciate that it can be helpful to have all documentation in one place, but as at the time of our last visit we found care files somewhat cumbersome and difficult to navigate. We discussed highlighting entries to easily identify specific notes. We had previously suggested the inclusion of a summary sheet that would give brief details about the individual young person such as their diagnosis, daily routines and any management concerns. Unfortunately we did not locate any such document but would suggest this may still be helpful to staff.

Recommendation 1:

The service manager and charge nurses should urgently review nursing care plans to ensure they address all the care needs of the patients and detail clear interventions, reviews and evaluations. The care plans should have a clear link to decisions made at MDT meetings.

Recommendation 2:

All professionals writing in care files should highlight their entries for ease of reference for all staff.

Recommendation 3:

The charge nurses should ensure a brief information sheet about each patient is available at the front of the relevant care file for all staff to access.

Use of mental health and incapacity legislation

We found legal documentation stored at the back of the care files where the young person was detained.

None of the young people in the ward at the time of the visit were subject to the Adults with Incapacity (Scotland) Act 2000.

Three patients detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) were receiving medication that required to be covered by a certificate authorising treatment (T3). These forms were in place. However, there was no copy of the form in the unit for one of these patients. For another patient the T3 form had been completed late. We raised this with the lead psychiatrist, and discussed the need for medical staff to ensure that they request a visit by a Designated Medical Practitioner in good time before a T3 form is required to authorise medication.

Rights and restrictions

The main door to the ward is locked at present for the safety and security of the patients. The reason for the door being locked has been discussed with the patients. The fact that the door may be locked from time to time is detailed in the unit information booklet given to patients and their carers on admission.

The patients have access to an enclosed garden area accessed from the lounge area of the ward.

Activity and occupation

Prior to our visit we heard from the Patients Council, Carers Council and relatives that there was a lack of activity available to the patients. Two relatives we spoke to on the day expressed concerns that they felt there were limited activities available in the unit. We heard that this issue had also been discussed at the community meetings. It was good to hear that the activity co-ordinators take patients out to participate in activities in the community as well as trying to provide a programme of activity in the ward. We are aware that activities on the ward can be repetitive and not always what the patients are looking to do. However, we were pleased to hear that they are encouraged to discuss this at the weekly community meetings and to put forward thoughts on what they would like to do. It was good to note that money for outings has been agreed from endowment funds.

We also heard that at busy times on the ward activities can be cancelled due to demands on staff time. We hope that the increase in staffing will support activities to carry on even when the ward is busy. We hope that there is an improved activity programme available during the school holidays and would like to be updated on progress in this area.

Recommendation 4:

Nursing and activity staff should ensure activity options appropriate to the patient group are available and happen throughout the week.

The physical environment

The communal areas of the ward are small but each patient has their own bedroom. Patients also have access to an enclosed garden area.

The ward is moving to the new children's hospital site in autumn 2017.

Any other comments

We heard from young people that staff are in general supportive and approachable. However, the patients and relatives spoken to raised concerns regarding the care plans and activities. We discussed these issues further at the end of the visit and have made recommendations regarding both of these issues.

We are also aware that there are specific complaints from parents that are currently being addressed by managers.

Summary of recommendations

1. The service manager and charge nurses should urgently review nursing care plans to ensure they address all the care needs of the patients and detail clear interventions, reviews and evaluations. The care plans should have a clear link to decisions made at MDT meetings.
2. All professionals writing in care files should highlight their entries for ease of reference for all staff.
3. The charge nurses should ensure a brief information sheet about each patient is available at the front of the relevant care file for all staff to access.
4. Nursing and activity staff should ensure activity options appropriate to the patient group are available and happen throughout the week.

Service response to recommendations

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

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

Mike Diamond

Executive Director (Social work)

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 MWC 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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