

Report on the joint unannounced visit/safe delivery of care inspection

Royal Hospital for Children and Young People
Melville Inpatient Unit

NHS Lothian
12 – 16 May 2025

Introduction

The Minister for Social Care, Mental Wellbeing and Sport committed to address the serious concerns raised by the BBC documentary (aired in February 2025) regarding the experiences of young people in Skye House in Glasgow. The Minister commissioned the Mental Welfare Commission for Scotland (the Commission) and Healthcare Improvement Scotland to carry out visits/inspections across all three young people units in Scotland and the separate children's in-patient psychiatric unit in Glasgow.

As part of this collaborative approach, Healthcare Improvement Scotland and the Commission committed to ensure that our skills, experience and resources were jointly used to deliver comprehensive, independent and robust assurance of the units.

The first unannounced visit/inspection undertaken, as part of this programme of visits, was to the Melville Unit.

The Melville Unit is a purpose built 12 bedded Child and Adolescent Mental Health Services (CAMHS) Inpatient unit based within the Royal Hospital for Children and Young People (RHCYP) in Edinburgh.

The unit is the regional inpatient unit for young people who live in the NHS Lothian, NHS Borders and NHS Fife areas. However, young people may also be admitted from other regions on an emergency basis if there are no available CAMHS beds.

About this visit/inspection

We undertook a joint unannounced visit/inspection to the Melville Inpatient Unit, NHS Lothian from Monday 12 to Friday 16 May 2025. Two different methodologies were employed and are described in part one (the Commission) and part two (Healthcare Improvement Scotland) of this report.

Whilst our approaches are different, they are also complementary. The context of systems, leadership and governance (the macro level) scrutinized by Healthcare Improvement Scotland has a direct relationship to the experience of those receiving care and treatment (the micro level and statutory focus of the Commission) and vice versa. The aim of this collaboration therefore was to jointly deliver enhanced, independent assurance of the unit.

The Commission and Healthcare Improvement Scotland would like to thank NHS Lothian, all staff at the Melville Unit, the young people receiving care and treatment at the Melville Unit, their families, advocacy staff and mental health officers for engaging in this joint unannounced visit/inspection process.

A summary of findings from this joint visit/inspection

A summary of findings, areas of good practice, and any recommendations and requirements identified are highlighted below. Details supporting these findings can be found within the main report.

Areas of good practice

1. The Commission and Healthcare Improvement Scotland observed positive interactions between staff and young people and were told by young people that they felt listened to.
2. All staff who engaged with us clearly expressed their commitment and passion for working with young people and their desire to support recovery. Staff we spoke with were generally positive about working on the unit and newly registered nurses told us they felt well supported.
3. Psychology input is viewed very positively and regarded as a valuable contribution to the multidisciplinary team.
4. Healthcare Improvement Scotland staff attended a showcase of quality improvement initiatives introduced by nursing staff. These included an initiative to aim to reduce the use of restraint required when administering nutrition by artificial means, weekly community meetings for young people and staff and the introduction of an online resource for young people and their families.
5. Healthcare Improvement Scotland staff observed the Melville Inpatient Unit daily safety huddles (rapid rundowns). These were concise and structured and included members of the wider multidisciplinary team such as dietitians, occupational therapists, patient coordinator and medical staff.
6. NHS Lothian have utilised their live time staffing tool to calculate required nursing staffing levels resulting in an increase in nursing establishment with good recent recruitment and retention rates. We also noted and welcomed young people being given the opportunity to contribute questions for interviews for staff as part of the recruitment process.
7. We were advised that NHS Lothian Child and Adolescent Mental Health Inpatient Services are currently developing a new model of care and patient pathway.
8. Some of the relatives/carers we spoke with were grateful for care provided however, they told us they felt that there could be more dietitian and psychology support (the service subsequently confirmed some additional psychology resource starting June 2025). All relatives/carers said that they felt that staff were approachable however, trust and confidence were caveated in terms of some staff being better than others.

Areas for improvement

1. The practical application and safe use of proportionate restraint as a last resort is a significant issue at the Melville Unit. Based on observation of practice, the impact on young people, the lack of detailed anticipatory care plans, incomplete recording of details post event and completion of the electronic incident reporting system, the approach to restraint in the Melville Unit requires further enquiry and improvement by the service.
2. Nasogastric tube feeding under restraint requires further enquiry and improvement by the service to ensure best practice is being followed and young people are given every opportunity to retain decision making as per best practice guidelines.

3. Authority to treat young people should be in accordance with the Mental Health (Care and Treatment) (Scotland) Act 2003. Lawful practice and understanding of roles and responsibilities has yet to be embedded at Melville Unit with no evidence of managerial oversight or action progressing following recommendations previously made by the Commission. This is an area which requires further enquiry and improvement by the service.
4. The issue of concerning multidisciplinary team dynamics has been a long-standing known issue at Melville Unit. Our direct observation and feedback given to us evidence that little progress has been made. This is an area which requires further enquiry and improvement by the service.
5. There appeared to be a disconnect between what activities were reportedly said to be available and the experience of young people particularly in the evenings and at weekends. Parents reported similarly. Some young people explained that this gap in provision meant they spent too much time thinking their own “thoughts”.
6. The quality of care planning, associated documentation and inclusion of parents/relatives remain an area that has yet to develop as recommended by the Commission previously.
7. Communication with young people and their families is an area highlighted for further improvement.
8. The maintenance of the environment to ensure staff and patient safety.

Part one: The Mental Welfare Commission (the Commission)

The Commission is an independent organisation originally established by the Mental Health (Scotland) Act 1960. It is uniquely placed to safeguard the rights and welfare of individuals with a learning disability, mental illness, dementia or related condition.

The Commission is also a corporate parent under the Children and Young People (Scotland) Act 2014, with duties conferred to promote and protect the welfare of care experienced children and young people. The rights of the child were further expanded through the United Nations Convention on the Rights of the Child (Incorporation)(Scotland) Act 2024 and therefore, as a listed authority, the Commission is also duty bound to act and report in compliance with this legislation and incorporated UNCRC articles.

Our Focus

Our focus is on individuals and their experience of care and treatment. We make sure that the care and treatment of a person with a mental health condition (children, young people and adults) is in line with the principles of both the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA 2003) and the Adults with Incapacity (Scotland) Act 2000 (AWIA 2000).

Section 13 of the MHA 2003 describes the visits that the Commission is authorised to undertake. Our engagement and participation officers, mental health nurses, social workers (mental health officers) and psychiatrists visit and speak to people who use services, their carers, their families, their advocacy supporters and their mental health officers so that we can understand what their experience of care is like. We aim to identify both good experiences but also areas of care, treatment and law which are not respecting the rights of

the person being cared for. We also speak with staff and managers to understand what they are doing to provide the highest quality care, treatment and support according to mental health and incapacity legislation.

Part one of this report will therefore focus on the individual person's experience of care and treatment and the lawful authority in place to support this and will be followed by part two which details Healthcare Improvement Scotland's methodology designed to support NHS boards in complying with national standards, improving patient outcomes, and identifying areas for improvement.

What we did

While the Commission's usual approach involves visiting a ward on one day, on this occasion we visited Melville Unit over a five-day period in May 2025. There were 10 young people receiving care and treatment in the 12 bedded unit, nine who were in the unit throughout our visit, with the tenth young person being admitted later on during our fifth day. Given the timing of this admission, we reviewed the care of only those nine young people who had been in the Melville Unit throughout the week of our visit.

- The length of stay of the young people in the Melville Unit ranged from less than one week to approximately five months. Eight young people were receiving care and treatment on a compulsory basis according to the Mental Health (Care and Treatment) (Scotland) Act 2003.
- Nine health records of the young people were reviewed by Commission staff and double read by a second different Commission mental health professional (that is, each record was reviewed by a nurse and a doctor, by a social worker and a nurse etc).
- We engaged with five young people and eight nursing staff who described themselves as the young people's key workers/named nurses.
- We engaged with the relatives/carers of eight young people.
- 17 of the multidisciplinary staff working directly on the unit provided us with information.
- We also received feedback from seven mental health officers and two advocacy workers working with the young people on the ward at the time of our visit.
- The Commission was also invited to attend a range of groups on the wards, for example, the wind down group, carers group, creative activity group and music therapy group.

What we heard

Children and Young People

What we expect:

Inpatient Child and Adolescent Mental Health Services (CAMHS) are regarded as Tier 4, that is, they are required to meet the needs of young people with the most complex, severe or persistent mental health problems¹.

We would expect young people receiving services in the Melville Unit to receive holistic, person-centred care delivered by an experienced, specialist, multidisciplinary team which is inclusive and recognises the young person as a unique individual. We would expect the young person to have a key worker/named nurse with whom they have built or can build a therapeutic and trusting relationship. We would expect young people to be fully aware of their rights, to be treated with dignity and respect and for all interventions to be lawful.

What we heard:

There were nine young people on the ward when we visited; we received feedback from five young people (one questionnaire was completed anonymously). One young person was too unwell to engage with us.

The link that Commission staff had access to the “Information leaflet for young people and families coming to the Melville Unit as an in-patient” did not open on the relevant page although HIS staff were able to access this link and noted that it was an area of good practice (Domain 1, p 33). Nevertheless, we heard from all young people who engaged with us that they had been given enough information about the ward/unit and were informed of their rights. They also all told us that they were able to see their parent or carer when they wanted to.

Although eight staff met with us and identified themselves as named nurses/keyworkers for the young people on the unit, the young people themselves did not understand that they had a named nurse or keyworker. Young people instead described ‘having a team’ or being able to speak to any staff. One person described the staff as “kind” and the majority of the young people who engaged with us reported that staff talk with them regularly about how they are feeling.

“Yes - I am getting better at this [speaking with staff] now however I would not at the beginning of my admission”.

The young people who engaged with us generally felt informed about legal status, advocacy, diagnosis and explained this in terms of the admission not being their first; most of them told us that they have a plan of what is going to happen to make them well so that they can leave the ward/unit. Where the young person had been centrally involved in the care planning, this made a significant difference:

¹ [NHS Scotland CAMHS Model \(2\).pdf](#)

“I have been involved in my plan and in this admission, I have been more involved than I was before which is good for me, and I feel hopeful that it will work”.

During our visit we noted a discharge planning care plan to adult services with no detailed documented transition planning. The Scottish Government produced clinical process guidance for young people moving between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services which was developed in consultation with CAMHS users to further Action 21 of the Mental Health Strategy: 2017-2027². We would expect these processes to be followed for the transition of a young person who has been diagnosed with a serious mental illness, particularly considering the investigation and recommendations from the Commission’s Mr D³ case. Instead, there was little evidence of transition work recorded.

Those young people who were prescribed medication told us that they understood why they needed it and most were unsure what would happen if they refused to take their medication. It was suggested by the young people that intramuscular medication (IM) would be given instead or it would be re-offered when next due. All of the young people reported that they feel staff listen to what they have to say about their care and treatment with some explaining there are particular staff who they would speak to as they had developed trusting relationships with them.

The young people who had experienced restraint said they had care plans in place for when they are struggling but did not agree that this was followed at times of difficulties. They also said that physical health checks were not done after restraint (also confirmed by named nurses/key workers that this was not routine practice) although staff did take time to talk to them afterwards and check they were okay.

Although those who engaged with us felt they were not discriminated or treated differently to others, there was a view that where distress may be quite “hidable” or it was difficult to communicate, some people may be left alone when they should not be. Relatives also suggested this was the case too.

No concerns were raised by the five people who engaged with us about the activities/access to education whilst on the ward/unit. Enjoying TV, education classes and Xbox was noted. There were suggestions for more art materials and board games chosen by young people rather than staff and also for there to be weekend activities. We were told there used to be a suggestion box for activities but this seems to have disappeared. Although these young people did not raise concerns, the time we spent on the ward talking to people, observing and attending groups highlighted that there is not enough for young people to do on the ward and neither is there an age-appropriate welcoming outdoor space; the garden is stark.

Whilst most young people said it was quiet enough to sleep at nighttime, their answer to this question and a question about feeling safe was caveated by the fact that it depended on where other patients were ‘in their journey’. Staff talking to and supporting young people at times of feeling unsafe or when the ward was noisy was acknowledged and welcomed, as were interventions such as the offer of noise cancelling earphones.

² <https://www.gov.scot/Publications/2018/08/8292>

³ [InvestigationIntoTheCareAndTreatmentOfMrD_2023.pdf](#)

None of the young people on the ward had completed an advance statement (despite some having experienced multiple admissions). It was not clear from the staff we spoke with who would discuss this with the young person; it was assumed that medical or advocacy staff might have these conversations. We have raised young people's rights to an advance statement following previous visits to the Melville Unit but despite assurances given, we found no progress.

The young people were asked to rate (on a sliding scale) how well they thought they were looked after on the ward/unit overall. One person chose not to answer and all others said "okay".

Carers/Relatives

What we expect:

Section 278 of the Mental Health Act places a duty on the NHS, and local authorities to take steps to mitigate the impact of detention on family relationships. This duty applies where a child is under 18, is detained or when a parent of a child is detained. This is in keeping with article 23 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and respect for home and family life.

We expect therefore that families should always be allowed and encouraged to offer information to professionals involved in a young person's care and treatment. In all situations, and regardless of the young person's consent or capacity, families can give information to the professionals involved and staff should listen to them. Families and carers know the young person best and can provide valuable information that does not breach the confidentiality of the relationship between the young person and the professional team. The Commission's *Carers, consent and confidentiality* good practice guide⁴ explains this in more detail but an inclusive approach to carers, relatives and people important to the young person cannot be understated.

What we heard:

Eight relatives/carers of the young people in the unit engaged with us during our visit to Melville Unit; two of whom also spoke to HIS staff (part two of this report Domain 4:1, p 40-48).

Their experiences ranged from a first admission to the unit for their son or daughter or multiple admissions. Those for whom there had been more than one admission, described challenges in receiving information and being included in decision making. For some "it has taken a while to get here" with formal complaints being made and social work support invoked to ensure inclusion. We heard concerns about unplanned discharges. Families felt unprepared for their child coming home. Another family told us about learning of very significant interventions from their young person and having had no opportunity to have one to one discussions with any staff.

⁴ [Carers, consent, and confidentiality](#)

All relatives/carers felt that when they did receive information or asked questions, staff were approachable and explained in terms which were understood by relatives/carers. There were very positive comments such as:

“Can’t fault staff” and “Staff are really brilliant people that work on the unit”.

However, trust and confidence were caveated in terms of some staff being better than others with concerns about use of bank staff and their lack of knowledge of the complex needs of individual patients. Much like the responses from the young people we engaged with, there was feedback about some excellent staff but this did not always extend to all. The majority of relatives/carers said there were not enough things for the young person to do in the ward/unit throughout the week and weekends/evenings. There was a suggestion to increase attendance of therapists, to allow young people access to board games/craft work rather than having them locked away with only staff being able to access (although risk assessments were highlighted), to stick to the activity plan (as it was noted the plan often is not delivered on), to progress the development of a sensory room/calm room that has already been talked about and to set up groups at the weekend to relieve boredom. All reported that there is ‘nothing to do at weekends’.

An adult carer support plan had not been discussed with six of the relatives/carers. One person did not think this would be of interest to them and another spoke positively about this following support from social work.

On a sliding scale of five points from very satisfied to dissatisfied, six relatives/carers described being satisfied with the care and treatment provided to their young person with two scoring lower. Seven out of the eight relatives/carers provided additional constructive feedback on how their experience and that of their child could be improved upon: from the contents of the induction pack, to discharge planning, to the provision of consistent information, to avoiding blanket approaches to treatment of anorexia, to sharing information and recognition of the role of the named person. We will share this detailed feedback with the unit.

Staff working directly on the unit

What we expect:

The 2020 Child and Adolescent Mental Health Services (CAMHS): national service specification⁵ explains the Getting It Right For Every Child (GIRFEC) approach and confirms that CAMHS should work on a multiprofessional basis towards shared decision making and formulation. We therefore expected to find a multidisciplinary approach to the care and treatment of young people in Melville Unit underpinned by respect for individual roles and contributions and characterised by positive collaboration between professionals.

⁵ <https://www.gov.scot/publications/child-adolescent-mental-health-services-camhs-nhs-scotland-national-service-specification/pages/3>

What we heard:

There is a wide variety of expertise and specialisms who contribute to the care and treatment provided on the Melville Unit. From education, to nursing, to medical, to music therapy, art therapy, psychology, dietetics, social work, family therapy and occupational therapy. We are grateful to the 17 staff who took time to speak with Commission visitors and/or complete the questionnaire provided.

All staff clearly expressed their commitment and passion for working with young people and their desire to support recovery and be:

“Genuine advocates for young people and their rights, try and ensure young people as on board as they can with their treatment. “Help make a difference and see people get better”.

Whilst staff reported enjoying their work, they also noted some frustrations:

“It feels like the nursing team’s views aren’t listened to which can be frustrating due to the level of knowledge and skills we have”

“Staff all want to do the right thing – but don’t always agree what that is”.

There was a commitment to ensure that young people were fully aware of their rights, whether detained in hospital or receiving care and treatment on a voluntary basis. Current training appeared to be focused on human rights training (which was welcome and appropriate) and understanding of rights in relation to mental health and incapacity legislation was regarded as the responsibility of nursing staff. Whilst most staff who engaged with us said they would direct any mental health/incapacity legislative related queries to nursing staff to address, there was also a view that this knowledge should be extended:

“I feel we could do with more training around this specifically in relation to detained patients”.

Whilst 14 of the 17 staff reported that they understand the relevant consent and decision-making requirements of legislation, some qualified this by explaining that they were “unsure”, had a “rough understanding”, it was a “work in progress” and following further exploration it was agreed that a greater depth of understanding than that reported was required particularly in relation to authority to treat. It was confirmed by managers that staff ‘learn as they go’ in relation to consent to treatment provisions of the act rather than any specific training.

Most staff confirmed that they had received child and adult protection training (primarily via LearnPro, an online training/learning system) and all staff reported that they feel confident and competent in their reporting duties in relation to adult/child protection.

All staff reported that they can speak up if they see practice which is not the best it could be. Additional comments included:

“Good here, everyone works hard to do things correctly and would pick up on any outliers”.

“Yes, but not confident it is acted on”.

10 out of 17 staff said they felt supported to do their job to the best of their ability with medical and psychology staff not feeling adequately supported. There is a consultant psychiatrist and consultant psychologist vacancy and nursing staff explained that nasogastric feeding challenges sometimes required additional staff numbers than those on shift.

We asked staff whether there were any challenges in relation to managing smoking/vaping as per legislative requirements. Whilst this was not an issue that had come to some staff's attention, others explained that nicotine replacement therapy is available and offered, unescorted passes out with the unit may be offered whilst others reported incidences of young people being allowed to smoke in the garden or at the front door of the unit to “avoid escalation”. It was reported that some staff did not agree with this.

Managers advised us that there are in fact fifteen minute ‘fresh air’ passes for the young people who vape and are 16 years and over. It was explained that older children may present as more of a risk if they cannot vape, and this is a factor of their being able to leave the ward.

When asked what gets in the way of giving the highest quality of care and treatment staff want to give to people, we were told:

Although there are a range of multiprofessionals involved on the unit there are capacity issues. There are vacancies in senior medical and senior psychology roles as noted above and reportedly not enough substantive roles (allied health professionals in particular; this was also confirmed by parents) to provide the therapeutic input required. This is said to impact on the strength of voice of some professionals in a multidisciplinary meeting “it is difficult to maintain a voice” and increases the risk of focus on the medical model at the expense of a more holistic, recovery-based approach:

“Very strong illness model adopted in ward so that adolescent behaviour is understood in an illness framework and thereafter the challenge becomes finding the right psychotropic medication”.

It was noted that a lot of nursing staff are new and they necessarily ask lots of questions but there is duplication and overlap in roles where the same questions might be asked more than once rather than through the nurse in charge. A further view suggested the need for stronger CAMHS informed leadership for nursing staff to support them to “not be afraid of making mistakes”; and to support learning and reflection towards continuous improvement, including in relation to restraint. An additional view suggested a “need for more mentoring of staff to ensure what has been taught is translated into practise when faced with real life situations”.

Leadership was once again a key theme raised by a number of staff, having been highlighted on previous Commission visits to the unit. This was particularly apparent in relation to senior nursing staff and the relationship with medical staff, with reports that this had an impact on young people's care, notably in relation to nasogastric tube feeding. Staff across disciplines reflected on “team dynamics”, “multiple leaders not working together” “differences between nursing and medical views”. Staff across disciplines said that their voices are not heard, they are exhausted by the dynamics of relationships and one staff member who is

“Very unhappy and dissatisfied” is now looking to change careers.

There is no doubt that the young people who require care and treatment in Melville Unit have a range of individual, very complex needs. We were told that acuity is increasing but there have been “so many knock backs” of referrals to intensive psychiatric care units that there is little expectation of any referrals being accepted. A concern was highlighted about the difficulty managing the range of needs of young people who do not have a diagnosed eating disorder because they can get a “a bit lost” as there is “so much focus on NG feeds and mealtime support”. This has been recognised as an issue by the service and there are plans to review the model of care, as noted in part two of this report (Domain 1, p30).

It was concerning to hear about the levels of violence and aggression:

“Assaults on staff (getting beaten up) take place very often. It doesn’t bother you as it seems a normal part of the job, I’m used to it”.

“Feels it’s becoming the norm to be assaulted at work... It feels the people in the team who aren’t exposed to this see it as being acceptable”.

“Distressing when get hit”.

Violence and aggression often leads to use of restraint:

“It’s the hardest job I’ve had mentally and physically – a lot of restraints”.

Whilst we heard of positive intervention by nursing and psychology staff to support a reduction in use of restraint and numbers of restraint going down as a result, we also heard that the perceived leadership difficulties meant this has not been embedded as well as anticipated.

Whilst the Melville Unit is described as a purpose-built building, the layout is said by staff to be a significant challenge when use of restraint is required and interventions can, in turn, impact the whole patient group.

“The ward becomes paralysed”.

“Too many things going on at the same time in such a small space”

“The stress and distress experienced by the YPs when witnessing violence and aggression contributes to causing them harm while an inpatient”.

One young person told us that it was not always easy to have privacy or space to talk to staff:

“I have been out of my room from 9am till 9pm so have had to choose my moment but it depends what is happening on the ward if I can. There is no sensory room or quiet space”.

One family member made explicit reference to the setting,

“The environment in the Melville unit is not therapeutic and each admission they keep getting worse”. Another relative suggested that “soundproofing of the ward would be great”.

Advocacy

What we expect:

The Mental Health (Care and Treatment) (Scotland) Act 2003 is clear about the vital importance of independent advocacy to ensure people's own voices are heard. Young people and adults have a legal right to independent advocacy whether they are subject to compulsory measures under the act or not. This right applies to everyone with a mental illness, personality disorder, learning disability, dementia or related condition, and to all types of independent advocacy⁶. Section 259 of the Act enshrines this in law.

We therefore expect that all patients are offered independent advocacy support and we would expect commissioned advocacy services to include specific advocacy expertise to enable young people to have as much control and influence on their care and treatment as possible given their current circumstances.

What we heard:

Two members of advocacy staff provided feedback during our visit to Melville unit. Both were or had been working with young people currently receiving care and treatment on the unit. Both noted that staff are very accommodating when trying to arrange meetings with young people albeit one referred to a 'strict timetable' on the ward which could hamper their ability to make arrangements for meetings.

No answers were given to the question about whether they felt advocacy was valued and respected in this setting.

Both felt able to raise any concerns with the senior nurse on the ward, their line manager and both said they would contact the Commission too if indicated. Neither made any reference to adult or child protection procedures.

Mental Health Officers

What we expect:

Mental health officers (MHOs) have statutory powers under the Mental Health Act to support the care and treatment of people whose mental health condition may require the protection afforded by legislation.

As social workers, MHOs' responsibilities include care planning, assessing mental health need and whether compulsory intervention may be required as well as ensuring the rights and welfare of individuals is protected. It is a critically important role and we would expect active involvement by MHOs in the care of young people whose liberty has been impacted by detention in hospital against their wishes. We would also expect that each young person has a current and relevant social circumstances report (SCR) on file which has been sent to

⁶ [6. Principles and Standards for Independent Advocacy Reflecting Commissioners' Statutory Responsibility - Independent advocacy: guide for commissioners - gov.scot](#)

the key recipient, the responsible medical officer and copied to the Commission (section 231 Mental Health Act). The content of an SCR is clearly set out in the Mental Health (Social Circumstances Reports) (Scotland) Regulations 2005 and their purpose in the Code of Practice (Volume 1 Chapter 11). The Commission has published good practice guidance in relation to SCR provision⁷ and also monitors the provision of these statutory reports.

What we heard:

Seven MHOs provided their views as part of this visit/inspection process. All were involved in working in partnership with the young people on the unit. Where MHO visits to the ward were somewhat limited, this was reportedly related to the distress caused to the young person by the visits. "I prioritise visits to do only those that are essential".

Four of the MHOs were routinely invited to the multidisciplinary ward meetings and the other three felt able to discuss attendance at the meeting with the responsible medical officer if they wished to.

One MHO had identified a concern and raised this with nursing staff who responded entirely appropriately. Other MHOs noted no concerns in the course of their work but felt able to raise matters either with the nursing staff, the responsible medical officer, their line manager or with the Commission. No one referred to adult or child protection processes or procedures in this context however six of the seven MHOs confirmed that they feel they are confident and competent in relation to their child protection/adult protection responsibilities.

Social circumstances reports (SCRs) were reportedly prepared or being prepared for five of the young people. The other MHO could not recall if they had completed an SCR or not and explained that the social work department is under a great deal of pressure with very large caseloads and prioritisation is for 'essentials' only. National standards for MHO services⁸ are clear that MHOs require to fulfil their statutory duties under the legislation in accordance with the principles of the legislation and the associated Codes of Practice and managers require to enable this. Whilst an SCR may serve little or no practical purpose, this should be stated and the reason should not be that the social work department is too busy.

Review of case records by Commission staff would suggest there should have been seven SCRs on record but none were located in the young person's case records or in information accessed during the Commission's visit to the unit.

MHOs generally spoke positively about their experience of the unit and the benefit to the young person they were working with. Specific issues raised related to the busyness of the ward and despite bespoke strategies being put in place for individual young people, them not always being followed through due to either staff being too busy or the use of bank staff. Concerns were also raised about the potential for young people to be discharged

⁷ [SocialCircumstancesReports_GoodPracticeGuide_2022_1.pdf](#)

⁸ <https://www.gov.scot/publications/national-standards-mental-health-officer-services/>

prematurely to allow for higher risk admissions to the small unit. One general issue highlighted for improvement was communication, particularly with named persons.

What else did we hear and learn?

What we expect:

We expect a culture of openness and respect for the Commission's duty in law to seek and receive a wide range of information including access to patient records. We also expect leaders to facilitate this process and to support their staff during the time the Commission and HIS are both on and off site.

What we found:

All operational staff we spoke with across the range of disciplines spoke openly and honestly about what works well at the Melville Unit and what the barriers are. Commission staff were invited to a range of groups (some of which were more embedded than others) and given additional opportunities to observe practice, for example a planned restraint intervention. The Melville Unit staff group clearly evidenced their commitment to working to the best of their abilities for the young people they are looking after.

During the course of our visit, we received information about a child protection referral/complaint made and separately about a work experience placement, both of which we will follow up with the service. (The service subsequently advised there was no foundation to the concerns raised with the Commission in relation to the work placement).

We also learned a great deal from our Commission mental health nurses, mental health officers (social workers) and psychiatrists jointly reading case records of all the young people in the unit and cross-referencing with incident records.

The following are the key findings which emerged from what we heard, what we observed and what we read.

Key findings

As noted previously, all operational staff at the Melville Unit evidenced their desire to achieve the best outcomes for young people in their care. It is important that senior leadership and management capitalise on this obvious commitment.

Nursing staff

The unit is currently working with high nursing staffing levels with good recent recruitment and retention rates. Some of the registered nurses are not registered mental health nurses (RMN) but are registered learning disability or children's nurses which is recognised as bringing some benefits and some challenges. There are six charge nurses to help support the number of newly qualified nurses.

Training

There has been excellent work carried out to develop a robust training plan for staff who are new to CAMHS; this is based on elements of the NHS Education Scotland (NES) essential CAMHS package as well as additional aspects that are specific to inpatient care.

Staff have also been enabled to undertake work in other areas of CAMHS, paediatrics and learning disabilities services to enhance their experience and skills. Staff are also trained in an introduction to quality improvement (QI), undertaking a small QI project. This training appears to have had a positive impact on staff retention and recruitment. Healthcare Improvement Scotland identify this as an area of good practice in part two of this report.

Staff wellbeing

Staff wellbeing is considered by the service with good support from management though this appears to be profession dependent: that some staff groups had more support available to them than others. Staff have access to supervision, reflective practice and debriefs (though immediate post incident debrief and support is more sporadic) – attendance at these can be dependent on ward activity and acuity and is voluntary.

Psychology

Psychology input is viewed very positively and regarded as a valuable contribution to the multidisciplinary team. There is a clinical psychologist based in the unit four days/week and one day consultant psychology input. The vacant consultant psychologist post is to be readvertised however there is a plan to base the consultant psychologist in the Melville Unit full time until the vacant post is recruited to. They will still only provide one day / week to the unit but will be more visible and more able to provide leadership oversight.

Use of restraint

The matter of restraint was a significant issue highlighted throughout the Commission's visit to the Melville Unit. We observed restraint, we read about restraint and we heard experiences of restraint.

There is no specific piece of legislation or Scottish guidance dealing with restraint setting out what is lawful in a hospital and what is not. The National Institute for Health and Care Excellence (NICE), provides guidance on the use of restraint for children and young people (NG10)⁹ and although it refers to English legislation, the principles can inform practice and local policies in Scotland. All practice however, should be informed by human rights law, specifically Article 3 (prohibition on torture, inhuman and degrading treatment, Article 8 (respect for autonomy, physical and psychological integrity) and Article 14 (non-discrimination).

Where restraint is considered necessary it should be the minimum required to deal with the agreed risk, applied for the minimum possible time¹⁰. The National Safety Council suggest

⁹ <https://www.nice.org.uk/guidance/ng10>

¹⁰ [Rights, risks and limits to freedom](#)

ideally having up to five people present to safely control a patient¹¹. NHS Lothian's restraint policy cautions:

“When staff are not trained or apply restraint incorrectly there is a risk that in order to maintain control they get more and more staff involved”.

There were young people at Melville Unit who were assessed as requiring planned restraint to support a lifesaving nasogastric tube feed. We were told that eight to 10 staff were involved in restraining one young person for nasogastric feeds. Healthcare Improvement Scotland made further enquiries in relation to the use and recording of restraint when artificial nutrition via a nasogastric tube was required (Domain 6, p51-56)

We directly observed eight staff restraining one young person and, despite raising this as a concern that day, we were told by staff that this was repeated the next day. When we escalated to managers, they subsequently reported to us that the second report had been an inaccurate account and that the restraint had only involved five staff, the other three staff had been ensuring the safety of the environment and supporting the administration of the feed as well as swapping between those who were restraining.

We noted poor recording of restraint in case records with little detail of type of restraint, where the restraint occurred or how many staff were involved, however the case record of another young person did evidence a detailed record of restraint involving six staff members with three staff members restraining the young person's legs. This floor restraint was recorded as lasting 2 hours 30 minutes.

Nursing staff were open that they would restrain with eight members of staff - two holding each arm, three staff holding legs and one using appropriate head hold. We were concerned this seemed disproportionate and could be reflective of poor technique/wrong holds being used.

When scrutinising recorded incident information (Datix), we could not determine whether the intervention we read about was lawful as the detail recorded made it difficult to do this. We noted that for a young person who may receive restraint three times per day in relation to nasogastric feeds, this would be recorded as one restraint only.

Out of 661 incidents (violence and aggression, self-harm, absconsion and other) reported over a two-year period, 533 (81%) of these incidents involved use of restraint according to Datix records. 13 of these reports provided detail which highlighted that more than five staff were involved (two involved current young people on the ward). There were 59 restraints used for young people currently in the unit to facilitate nasogastric feeds (although the point above should be noted that three restraints in one day will be recorded as one only at Melville Unit).

We were concerned to note a previous (2023) whistle blowing concern had been made about the alleged overuse of restraint in Melville Unit. The response from the service did not

¹¹ <https://www.nsc.org/getmedia/a291988d-7fc6-4fbc-98f3-76ac5f7f0570/patient-restraints-english.pdf.aspx>

appear to address this concern, focusing more on lack of experienced staff (which may have been a contributing factor). There was not a record of the investigation looking at restraint practice, techniques used or proportionality, though this may be included in the fuller whistle blowing investigation report which has yet to be shared with the Commission.

The service's approach to restraint, its practical application and its role in patient care requires further exploration and inquiry. While the intentions behind using restraints may be rooted in safety and care, the potential risks and consequences cannot be ignored. We heard of bruising and a relative spoke of the "trauma of a restraint that lasted over 1.5 hours". There was also involvement of police and security staff in restraint when staff found situations unmanageable. This resulted in one case of handcuffs and Velcro leg cuffs being used.

The service must ensure that they are using restraint with the welfare of the young person in mind and clearly navigating the young person's rights in relation to its use.

Mealtimes and NasoGastric tube feed (NGT)

UK best practice guidelines¹² for nasogastric tube (NGT) feeding under restraint confirms that this practice should always be a measure of last resort when best efforts to support oral nutrition fail with subsequent deterioration in physical health. Whilst it is recognised that NGT feeding under restraint may be required in 'lifesaving circumstances', these circumstances are not clearly defined and require to be determined by the full multidisciplinary team.

Five young people were requiring NGT feeds during the week we visited. Our observations of approaches to individual care are as noted below.

Mealtimes appeared well supported with one to one support as required in the dining room. There were personalised areas with person-centred plans and placemats the young people had made reminding them of their goals and suggestions about what made meals easier for them. The young people were all offered meals and attempts were made to suit their specific tastes but this was problematic. Due to the number of young people with specific preferences and requirements (particularly those diagnosed with autism) there were large amounts of young people's own food stored in the ward fridge. This could cause difficulty regarding knowing who the food belonged to and for server staff knowing who got what food.

If young people did not manage their meal plan or part of it, they were offered the corresponding amount of a meal replacement drink; this was clearly set out in individualised meal plans. They had a set amount of time to drink this supplement; if it was not managed in the set time an NGT feed would be given.

NGT feeds would be given after each main meal and could include the previous snack if missed. Staff reported previous difficulties that feeds might be given close to meals which would leave the young person feeling full up and less likely to manage a meal. We were told that this had happened less since the number of young people admitted who required NGT

¹² [Naso-Gastric-Tube-feeding-under-restraint.pdf](#)

feeding was capped at 5. We enquired what happened if there was a young person requiring admission who was expected to need NGT feeding but there were already 5 young people in the unit receiving NGT feeds (as was the case during the time we visited). We were told there would be a clinical discussion about who could potentially stop NGT feeds and if the admission could go ahead.

When NGT feeding was required, we observed that young people were told this 15-30 mins before the feed. As required medication was offered, in some cases, before the feed to help with distress the feed would cause. This was discussed with young people and available if they were accepting of it.

We observed how the knowledge of a planned NGT feed changed the atmosphere in the unit; all the young people and staff appeared tense and watchful. Feeds were mainly done in the treatment room but sometimes this happened in the day room because of the individual needs of the young person (we were told that up to three of the young people in the ward when we visited might need to receive this treatment in the day room). When this was required, staff moved the other young people to other areas of the ward to ensure privacy. Due to the lay out of the ward this would mean that other young people could not access their rooms for the duration of the feed and for some time after if the young person was distressed.

We learned that young people had one offer only and were not given any other opportunity to drink the supplement before being NGT fed. Staff explained that they would be concerned the young person would take too long and just use another offer of a drink as a mechanism to put off the feed and extend their distress. Nursing staff did say that if a young person said they would drink it they might be allowed to, but it would not be offered routinely. This is contrary to the British Dietetics Association's best practice guidance (page 1) which states "At the point of passing NGT the patient should be offered another opportunity to take nutritional supplements / water orally in order to ensure that least restrictive practice is being carried out and that every opportunity to take oral food and fluid has been offered".

Mental Health Act legislation / authority to treat

The Mental Health Act provides the authority for compulsory treatment of individuals under strict circumstances and describes important safeguards for individuals as to how medical treatment, such as medication, NGT feeding and ECT may be lawfully authorised. Part 16 of the 2003 Mental Health Act¹³ describes these requirements which seek to ensure that the rights of patients are sufficiently upheld and protected at a time when they are unwell and may be unwilling to receive treatment or be admitted to hospital on a voluntary basis.

The Commission has raised concerns about lawful practice in relation to authority to treat young people at the Melville Unit for some time. During this visit, we found that lawful practice has yet to be embedded. Care records evidenced that a number of young people were receiving medication that was not lawfully authorised and indeed there were some historical gaps in lawful authority for their treatment prior to our visit.

¹³ [MedicalTreatmentUnderPart16MHA_2021_0.pdf](#)

We found no evidence of managerial oversight or action progressing following recommendations previously made by the Commission.

We were, however, able to see a copy of an audit undertaken in June 2024 by a former consultant psychiatrist but there were no entries after July 2024 and no one we spoke to in the service during our visit knew where the audit was located. Importantly, compliance with part 16 requirements involves the patient's consultant psychiatrist. During our visit we were concerned to hear that the consultant psychiatrist part time vacancy in the unit had not been filled. This meant that the unit had even less resource available to ensure important treatment safeguards were in place and adhered to.

An important aspect of ensuring that an individual's treatment is lawfully authorised relates not just to authority for treatment being obtained but also ensuring that it is exercised. We would expect that copies of treatment forms are available to support nurses when they dispense treatment to individuals on the ward, acting as a reference point to ensure the treatment that an individual is receiving is lawfully authorised.

Concerningly, on the first day of our visit to the Melville Unit, there were no paper copies of treatment forms that could be located by staff (other than for some young people already discharged from the unit). These forms should be held in the dispensary next to the medicines.

By the second day many but not all copies in a paper format were put in the dispensary folder if they were available. This absence of the relevant treatment forms in the dispensary folder would suggest that the nurses were not checking the authority to treat before dispensing medication to the young people we met when we visited. Whilst our observation of drug rounds and discussion with nurses in the unit demonstrated some knowledge regarding the theory of treatment forms as key safeguards this did not appear to translate into its practical application of using these forms to ensure medication was authorised. These discussions also highlighted a perception that nurses believed these forms were the responsibility of the medical staff and that nursing staff had no role relating to this despite their responsibility to administer medication.

Whilst there were elements of excellent training initiatives as noted above, some nursing staff did identify a gap in knowledge around the Mental Health Act (including advance statements, advocacy rights, restrictions and legal authority to treat). Whilst we noted that staff were encouraged to attend the Commission and NES training webinars, further bespoke investment in upskilling staff at the Melville Unit is required.

Team dynamics

The issue of concerning multidisciplinary team dynamics has been a long-standing known issue at the Melville Unit. The Commission has raised this matter previously as has a whistleblowing complaint in 2023. We were told by the service that work is ongoing regarding these issues however our direct observation and feedback given to us evidence that little progress has been made.

Whilst it is not appropriate to detail relational matters between professionals here, it is important to state that some of these dynamics are impacting on patient care. We will follow up on individual cases where indicated. It is also important to state that whilst standard operating procedures have been developed to address different professional opinions, these need to flex to meet the individual needs and outcomes of young people.

We were told it is difficult to progress any decisions that are made with the team due to the difficult dynamics unless it is a single rather than multi- professional action. This needs to be addressed as a matter of urgency to ensure that the model of service delivery and the professionals involved meet the holistic needs of the most vulnerable young people with the most complex mental health needs at the Melville Unit.

Care planning

The service has recently moved over to the NHS Lothian mental health person centred care plan template which covers 14 domains (person-centred; mental health; stress & distress; meaningful activity; legislation; continuous intervention; substance /alcohol misuse; functioning/activities of daily living; physical health; mobility and falls, food, fluid and nutrition; communication care plan; family, friends and carer engagement; and discharge planning). There is also a risk assessment with associated crisis plan and distress management plan.

Whilst there were excellent records of regular one to one discussions with young people in notes this rich information did not then get used in the care plan. This was a missed opportunity.

The quality of completion of care plans was inconsistent and the various systems for recording did not intuitively link together. It was difficult to navigate across domains and there was limited evidence of involvement of the young people in the care planning process.

We observed some care plans that related to the use of restraint, NGT feeds, the mental health act (including authority to treat) or seclusion in the e-health records however, for some young people where these should have been in place, we could not find the relevant care plans for restraint and seclusion. When these interventions are being used or anticipated we would expect to see a detailed care plan with de-escalation steps to be taken and ways to reduce distress. Healthcare Improvement Scotland also reviewed some care plans and found variation in the completion of these and have made a requirement relating to this (see part two of this report).

Managers advised there is no overall collation of the use of seclusion over a period of time. It is only when the individual is secluded that this would be recorded, but the data would then be lost after the young person has been discharged. Whilst seclusion was recorded well in notes with timings and reviews detailed, the lack of care planning was concerning.

We heard from staff and families that discharges could be reactive to bed pressures with families feeling discharge lacked proper planning. We noted several young people who had experienced several failed discharges with them only being back home for between 1 and 3 weeks before requiring readmission.

Our finding is that the notes in the Melville Unit provide an atomised approach with information spread across many recording systems and a lack of a cohesive plan that professionals use to plan assessment, care, treatment and discharge from. Healthcare Improvement Scotland has made a requirement in relation to care plans. (See part two of this report domain 4.1)

Family Involvement

We found that there was inconsistent family involvement. Some families were included in care planning and had regular meetings with key workers while others reported having never met individually with the nursing team. All had been offered the opportunity to attend the multidisciplinary team meeting, though some felt this was more a tick box exercise and that decisions had been made before they were included in the meetings (young people and family members are invited to attend the latter part of the meeting).

There is a carers group weekly run by social work and evidence that some family members were supported to access their own advocacy or carer's assessment and signposted to BEAT carers group. There was no information to suggest that support was routinely offered to siblings although it was noted that the invaluable contribution of the systemic family therapist could extend to this.

Families reported not being informed of incidents of restraint and seclusion when they happened, one family member had made a complaint about this. Another family member reported they had not been informed of their child (aged under 16 years) being reported to the police by unit staff following an assault on staff. They only learned about this when the police contacted them. Healthcare Improvement Scotland has made recommendation and requirement in relation to communicating with and involving families. (See part two of this report domains 4.1 and 6).

Activity / Education

Senior staff spoke positively about the range of activities and options for young people to spend their time on the ward however this did not translate into practice based on observations and reports from young people and their relatives.

Activity in the unit appeared to be reliant on the occupational therapist who worked Monday – Friday, 9-5 in the ward area.

There appeared to be set activities with some young people talking positively about the therapist and music group. It was not clear how the unit activities were tailored to individuals however and boys, in particular, chose not to engage. Whilst the nursing team played football with one of the boys, they would encourage the others to come out of their room without much success. In part two of this report, Healthcare Improvement Scotland have made Requirement 4 in relation to meaningful activity.

Almost all the young people we spoke to complained of feeling bored in the evenings and weekends (confirmed by their relatives/carers). They also told us that they had suggested planning trips out in the evenings and at weekends but these never happened. One

individual had been in the unit for some time and the only trips out they had were to the shop on the hospital campus. This was despite being settled and managing time out.

Some young people attended school; this was decided by their ability to manage school and their agreement to go. The school for the Melville Unit covers the whole of the hospital site, it is not a specific provision for the young people which perhaps limits the intensity of support available to the young people.

The activity suggestion box has disappeared as noted by the young people we spoke with. If this is to be reinstated, it will be important to ensure that suggestions are fully considered and responded to. Healthcare Improvement Scotland has made a requirement in relation to meaningful activity (see part two of this report domain 4.1).

Summary of findings

Although there are some key vacancies (notably psychology, psychiatry) the Melville Unit benefits from high numbers of nursing staff and a multi-disciplinary team committed to working to the best of their abilities for the young people they support.

From our five-day Monday to Friday visit to the Melville Unit in May 2025, the Commission's findings and issues arising requiring further action can be summarised as follows:

1. The practical application and safe use of proportionate restraint as a last resort is a significant issue at the Melville Unit. Based on observation of practice, the impact on young people, the lack of detailed anticipatory care plans, incomplete recording of details post event and completion of the electronic incident reporting system, the approach to restraint in the Melville Unit requires further enquiry and improvement by the service.
2. Nasogastric tube feeding under restraint requires further enquiry and improvement by the service to ensure best practice is being followed and young people are given every opportunity to retain decision making as per best practice guidelines.
3. Authority to treat young people should be in accordance with the Mental Health (Care and Treatment) (Scotland) Act 2003. Lawful practice and understanding of roles and responsibilities has yet to be embedded at the Melville Unit with no evidence of managerial oversight or action progressing following recommendations previously made by the Commission. This is an area which requires further enquiry and improvement by the service.
4. The issue of concerning multidisciplinary team dynamics has been a long-standing known issue at the Melville Unit. Our direct observation and feedback given to us evidence that little progress has been made. This is an area which requires further enquiry and improvement by the service.
5. There appeared to be a disconnect between what activities were reportedly said to be available and the experience of young people particularly in the evenings and at weekends. Some young people explained that this gap in provision meant they spent too much time thinking their own "thoughts".

6. The quality of care planning, associated documentation and inclusion of parents/relatives remain an area that has yet to develop as recommended by the Commission previously.
7. Communication with young people and their families is an area highlighted for further improvement.
8. The maintenance of the environment to ensure staff and patient safety.

Whilst staff on site and those visiting (advocacy, mental health officers employed by local authorities) reported feeling confident in their training in relation to adult and child protection reporting responsibilities, no one we spoke with explicitly referenced these if they observed any concerning practice on the unit. Instead, they suggested they would report any observed concerning practice to the ward and/or the Commission.

Summary

The Commission has visited the Melville Unit and made various recommendations over the past four years. It is good to note that nurse staffing levels are now much higher as this had been a significant concern previously.

Unfortunately, this enhanced visit over five days during May 2025 has highlighted that many of the other recommendations made by the Commission in recent years and the various action plans put in place by NHS Lothian, in response, have not effected significant change.

Findings 1-4 noted above now require clear actions from NHS Lothian on how these care and treatment issues are to be addressed and improvement evidenced in practice. This should include reflection on previous NHS Lothian action plans and why these have not delivered intended outcomes.

Findings 5 – 8 are addressed by Healthcare Improvement Scotland in part two of this report where recommendations and requirements are made in relation to these key areas for improvement.

It is important to note that whilst action plans, policies and standard operating procedures may be in place to support the delivery of safe and effective care, observations and reports confirm there has been little progress towards improvement of the individual experiences of young people and their families on the unit following previous recommendations made by the Commission.

Part Two: Healthcare Improvement Scotland (HIS)

Our Focus

The role of Healthcare Improvement Scotland is to support, ensure and monitor the quality of healthcare in Scotland by providing objective and independent quality assurance of healthcare services provided in Scotland

The organisations core purpose is to enable the people of Scotland to experience the best quality health and social care, with a specific focus on safety. It is part of Healthcare Improvement Scotland's Safe Delivery of Care Inspection Methodology to review systems, culture, leadership and governance of areas inspected.

The statutory duties for Healthcare Improvement Scotland are set out in the [Public Services Reform Act \(Scotland\) 2010](#) and the [National Health Service \(Scotland\) Act 1978](#).

Healthcare Improvement Scotland has adapted the safe delivery of care inspection methodology to minimise the impact of inspections on both the young people receiving care and the staff delivering that care. Our inspection teams are carrying out as much of their inspection activities as possible through observation of care and virtual discussion sessions with senior hospital managers. We will keep discussion with clinical staff to a minimum and reduce the time spent looking at care records.

From April 2023 our inspection methodology and reporting structure were updated to fully align to the Healthcare Improvement Scotland Quality Assurance Framework. Further information about the methodology for safe delivery of care inspections can be found on our website. Child and Adolescent Mental Health Inpatient Services inspection programme – Healthcare Improvement Scotland.

Our inspections consider the factors that contribute to the safe delivery of care. In order to achieve this, we:

- observe the delivery of care within the clinical areas in line with current standards and best practice
- attend hospital safety huddles
- engage with staff where possible, being mindful not to impact on the delivery of care
- engage with management to understand current pressures and assess the compliance with the NHS board policies and procedures, best practice statements or national standards, and
- report on the standards achieved during our inspection and ensure the NHS board produces an action plan to address the areas for improvement identified.

About this inspection

We carried out an unannounced inspection to The Melville Inpatient Unit, NHS Lothian on Monday 12, Thursday 15 and Friday 16 May 2025 using our safe delivery of care inspection methodology. During our inspection, we:

- inspected the unit environment
- observed staff practice and interactions with patients
- spoke with young people, relatives/visitors and ward staff, and
- accessed patients' health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Lothian to provide evidence of its policies and procedures relevant to this inspection. The purpose of this is to limit the time the inspection team is onsite, reduce the burden on ward staff and to inform the virtual discussion session.

On 13 June 2025, we held a virtual discussion session with key members of NHS Lothian staff to discuss the evidence provided and the findings of the inspection.

The findings detailed within this report relate to our observations within the area we inspected at the time of this inspection.

A summary of our findings

Our summary findings from the inspection, areas of good practice and any recommendations and requirements identified are highlighted as follows. Detailed findings from the inspection are included in the section 'What we found during this inspection'.

During our onsite inspection we observed positive interactions between staff and young people. Staff we spoke with were positive about working on the unit and newly registered nurses told us they felt well supported.

We were able to attend a showcase of quality improvement initiatives introduced by nursing staff. These included an initiative to aim to reduce the use of restraint required when administering nutrition by artificial means, weekly community meetings for young people and staff and the introduction of an online resource for young people and their families.

We observed the Melville Inpatient Unit daily safety huddles (rapid rundowns). These were concise and structured and included members of the wider multidisciplinary team such as dietitians, occupational therapists, patient coordinator and medical staff.

NHS Lothian have utilised their live time staffing tool to calculate required nursing staffing levels resulting in an increase in nursing establishment.

We were advised NHS Lothian Child and Adolescent Mental Health Inpatient Services are currently developing a new model of care and patient pathway.

Families we spoke with were grateful for care provided. However, they told us they felt that there could be more dietitian and psychology support. Young people we spoke with told us that whilst they enjoyed the activities provided, weekends could be boring.

Areas for improvement identified, include consistent completion and review of care records, communication with young people and their families and the maintenance of the environment to ensure staff and patient safety.

What action we expect the NHS board to take after our inspection

The inspection of the Melville Unit resulted in 14 areas of good practice, two recommendations and 14 requirements.

A requirement in the inspection report means the hospital or service has not met the required standards and the inspection team are concerned about the impact this has on patients using the hospital or service. We expect all requirements to be addressed, and the necessary improvements implemented.

A recommendation relates to best practice which Healthcare Improvement Scotland believe the NHS board should follow to improve standards of care.

We expect NHS Lothian to address the requirements. The NHS board must prioritise the requirements to meet national standards. An improvement action plan has been developed by the NHS board and is available on the Healthcare Improvement Scotland website: <http://www.healthcareimprovementscotland.scot/>

Areas of good practice

The unannounced inspection to The Melville Unit resulted in 14 areas of good practice.

Domain 1

- | | |
|---|---|
| 1 | Introduction of a patient coordinator role to support referrals, admissions and discharges (see page 33). |
| 2 | Introduction of a detailed online digital information resource for young people and their families (see page 33). |

Domain 2

- | | |
|---|---|
| 3 | Staff we spoke with were positive about working on the unit and newly registered nurses told us they feel supported by the team (see page 39). |
| 4 | The use of data from an electronic real time staffing tool to review and increase nursing establishment based on acuity and dependency (see page 39). |
| 5 | Availability of regular reflective practice and debrief sessions for staff with the psychology team (see page 39). |
| 6 | Complex case reviews include peer support from other regional child and adolescent mental health units and specialties (see page 39). |
| 7 | Daily Melville Inpatient Unit safety huddles “rapid reviews” were person-centred, structured and concise with good multidisciplinary team representation (see page 39). |

Domain 4.1

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|---|--|
| 8 | We observed positive interactions between staff and young people (see page 48). |
| 9 | Visits from players from professional football teams to play football with young |

	people (see page 48).
10	Young people told us they particularly enjoyed visits from the Therapet dogs (see page 48).
11	Medications were stored securely (see page 48).

Domain 6

12	Quality improvement initiative being implemented with the aim to reduce required restraint during the administration of nutrition via nasogastric tube (see page 56).
13	Introduction of Melville Inpatient Unit community meetings (see page 56).
14	Use of two interview questions written by young people for recent interviews (see page 56).

Recommendations

The unannounced inspection to The Melville Unit resulted in two recommendations.

Domain 4.1

1	NHS Lothian should consider providing a way for parents, carers and young people to provide feedback directly to the Melville Inpatient Unit (see page 48).
2	NHS Lothian should consider adding self-harm prevention training to mandatory training for Melville Inpatient Unit staff (see page 48).

Requirements

The unannounced inspection to The Melville Unit resulted in 14 requirements.

Domain 2

1	NHS Lothian must ensure enough staff are on duty who are trained in restraint to respond to staff personal alarms at all times (see page 39). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 and Quality Assurance Framework (2022) Indicator 2.14 and 6.1.
2	NHS Lothian must ensure all staff who administer rapid tranquilisation have completed intermediate life support training (see page 39). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 and Quality Assurance Framework (2022) Indicator 2.14 and 6.1 and Quality Network for Inpatient CAMHS Standards for Services (2021) Criteria 2.3.3.
3	NHS Lothian must ensure timely review and implementation of lessons learned from reported incidents including significant adverse events (see page 39). This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) criteria 2.5, 2.6, 4.1, 6.1, 6.7, 7.3 and the National Framework for Reviewing and Learning from Adverse Events in NHS Scotland (2025).

Domain 4.1

4	NHS Lothian must ensure meaningful activity is consistently provided, including evenings and weekends and that activity plans are completed and updated in care
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plans (see page 49).

This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) criteria 2.2, 6.1, 6.2, 6.6 and Health and Social Care Standards (2017) 2.21 and 2.22.

- 5** NHS Lothian must ensure effective communication with families and young people including care planning, meal plans, passes and any restrictions put in place (see page 49).

This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) criteria 2.2, 6.1, 6.2, 6.6, 6.7 and Health and Social Care Standards (2017) criterion 2.1 and 2.6.

- 6** NHS Lothian must ensure that all documentation is accurately and consistently completed and reviewed. This includes activity plans, nasogastric bolus charts, and risk assessments (see page 49).

This will support compliance with: Quality Assurance Framework (2022) Criteria 2.6, 4.1, 6.1, 6.5, 6.7 and relevant codes of practice of regulated healthcare professionals.

- 7** NHS Lothian must ensure all environmental risks are identified, and risk assessed to mitigate potential risks arising from the physical environment (see page 49).

This will support compliance with: Quality Assurance Framework (2022) criteria 2.6, 4.1, 6.1, 6.7 and Quality Assurance Framework (2022) criterion 5.1.

- 8** NHS Lothian must ensure the care environment is consistently maintained to ensure staff and patient safety including timely reporting of maintenance requests (see page 49).

This will support compliance with: This will support compliance with: Quality Assurance Framework (2022) criteria 2.6, 4.1, 6.1, 6.7 and Health and Social Care Standards 2017 criterion 5.17 and 5.22.

- 9** NHS Lothian must ensure the safe disposal of sharps (see page 49).

This will support compliance with: This will support compliance with: National Infection Prevention and Control Manual (2023).

Domain 4.3

- 10** NHS Lothian must ensure completion of the staffing level tool as part of the common staffing method (see page 50).

This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.

Domain 6

- 11** NHS Lothian must ensure that young people and their families are involved in planning their care and that this is clearly documented including regular one to ones (see page 57).

This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) criteria 2.2, 6.1, 6.2, 6.6 and Health and Social Care Standards

	(2017) 2.21 and 2.22.
12	NHS Lothian must ensure necessary medication is available in an emergency (see page 57). This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) criteria 2.2, 6.1, 6.2 and 7.3.
13	NHS Lothian must ensure any outstanding improvement actions highlighted within the Royal College of Psychiatry Quality Network for Inpatient CAMHS (QNIC) internal audit are actioned see page 57). This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) Criterion 2.2, 2.6, 6.1, 6.2, 6.7, 7.3 and Quality Network for Inpatient CAMHS standards for services criteria 2.3.3.
14	NHS Lothian must ensure adequate provision of a full range of dietary options (see page 57). This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) criteria 2.2, 6.1, 6.5 and Health and Social Care Standards (2017) criterion 1.33 and 1.37.

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

Staff told us of the development of a new model of care and patient pathway for the Melville Inpatient Unit. Staff were complimentary about the role of the patient coordinator in supporting admissions and discharges.

As stated previously, the Melville Inpatient Unit is a Tier 4 specialist Child and Adolescent Mental Health Service based within the Royal Hospital for Children and Young People in Edinburgh. Child and Adolescent Mental Health Tier 4 services are highly specialised units, for young people who require assessment and treatment for complex mental health needs. The Melville Inpatient Unit cares for young people from the age of 12-17 who may have a range of mental health illnesses including eating disorders, depression and psychosis. The unit is the regional inpatient unit for young people who live in the NHS Lothian, NHS Borders and the NHS Fife area. However, young people may also be admitted from other regions on an emergency basis if there are no other available beds.

Staff told inspectors about the role of the Melville Unit patient coordinator and how this was helpful in providing support for referrals, discharges and transitions from young people to adult services. The patient coordinator is the first point of contact in hours for referrals and potential admissions and links in with other Child and Adolescent Inpatient Services within Scotland. The role also includes attending the young person's weekly review meetings, supporting discharge planning and managing bed availability. Out of hours, the nurse in charge of the Melville Inpatient Unit and/or consultant psychiatrist will be first point of contact for referrals.

The Melville Inpatient Unit has 12 individual bedrooms. However, staff told us that two beds had been closed to promote patient safety. We discussed this with senior managers who advised that the decision had been made to reduce bed numbers in September 2022. This was in response to a junior nursing staff skill mix, an increase in patient acuity and dependency and an increase in numbers of young people requiring nutrition by artificial means via nasogastric feeding tube. We were also advised that an assessment of patient safety and support was carried out from this and it was decided that a maximum of five young people who required nutrition via nasogastric feeding tube should be admitted to the unit at any one time. Nutrition by artificial means will be discussed further in domain 6 of this report.

Staff advised that occasionally an additional 11th bed may be utilised on a risk assessed and short term basis. For example, if another young person was due to be discharged, enabling the unit to return to 10 beds once the young person had been discharged. From March 2023-March 2024, 34.2% of young people under the age of 18 were admitted out with NHS specialist child and adolescent mental health services across Scotland (Public Health Scotland Quality Indicator profile for Mental Health, November 2024). Staff advised inspectors that if there are no available beds that young people may be admitted to another inpatient child and adolescent mental health unit within Scotland. Young people may also be admitted to adult mental health units or children and young people's wards within general hospitals. We were also advised that if the young person is detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, in a general ward setting, that mental health trained staff would be in attendance. There were no young people waiting to be admitted to the Melville Inpatient Unit during our onsite inspection.

NHS Lothian Child and Adolescent Mental Health Inpatient Services are currently developing a new model of care and patient pathway. The options being considered included moving the service to the Royal Edinburgh Hospital, keeping all beds at the Royal Hospital for Children and Young People or splitting the service across each site. Senior managers advised that after an initial options appraisal that it had been agreed that the preferred model would be the split model across both sites.

Senior managers told us a workshop was held with Melville Inpatient Unit staff, to consider the number of beds at the Melville unit which would be specifically for young people who are being treated for an eating disorder with the remaining beds at the Royal Edinburgh Hospital being for young people who are being treated for other mental health illnesses. We asked senior managers if staff would be given a choice of preference as to which area they worked in and were advised that there would be a staff consultation period to discuss this. Staff we spoke with appeared to be supportive of the proposed new approach.

There were 10 young people being cared for within the unit during our onsite inspection. The majority of the young people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. The provision of the Mental Health (Care and Treatment) (Scotland) Act 2003 is intended to ensure that care and compulsory measures of detention can only be used when there is a significant risk to the safety and welfare of the patient or others.

The unit shared with us the "Young People and Families Welcome Information" resource which can be accessed online and has a link to a virtual tour of the unit. This includes

information such as what to expect on admission, who is in the multidisciplinary team and information about advocacy services including contact number and email address. Advocacy services provide independent support to young people to ensure they have the information needed about their rights and choices.

Staff told us that a new digital information resource has been developed as part of quality improvement work and was undertaken by newly qualified registered nurses in response to parents, carers and young people's feedback. This has a QR code which when scanned opens a link to a detailed online information resource. This includes information such as a welcome pack, ward information and routines, Mental Health (Care and Treatment) (Scotland) 2003 Act and the times of the parents and carers support group. It also provides information on how to provide feedback and raise concerns including how to contact NHS Lothian patient experience team, advocacy and the Mental Welfare Commission.

Staff advised that the QR code will be available for community child and adolescent mental health services within NHS Fife, NHS Lothian and NHS Borders so that the information can be shared prior to any young person being admitted. At the virtual discussion with NHS Lothian senior managers, we were told that the resource was now available and running alongside the original Young People and Families Melville Inpatient Unit Welcome Information resource. We were also told that a digital resource is in development to provide information for staff.

A key right for patients who are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 when being admitted to hospital includes the explanation of their rights and the reason for their detention. Inspectors observed the use of a whiteboard in the staff office within the Melville Inpatient Unit which has relevant information relating to young people's care, including if they had had their rights explained. We could see from this that two young people had not had their rights explained. We raised this with staff who advised that this was due to the young people not having the capacity to retain the information currently. We were also informed this was reviewed on a regular basis and once able to retain the information the young people would have their rights explained. Staff also explained that it is documented on the young person's electronic care records when they have had their rights explained.

NHS boards play a crucial role in child protection and child support. Child protection training provide staff with the information required to promote the protection and wellbeing of children. It also highlights the process to follow if staff are concerned that a child has been or is at risk of being harmed. We asked NHS Lothian for staff training figures for child support and protection which shows that 79% of staff have completed advanced child protection training. NHS boards also play a crucial role in adult support and protection. Senior managers advised they were unable to provide training compliance for adult support and protection due to NHS Lothian currently transferring data across electronic platforms. NHS Lothian should continue to monitor this to ensure the right staff with the right skills are in the right place at the right time.

Areas of good practice

Domain 1

- | | |
|---|---|
| 1 | Introduction of a patient coordinator role to support referrals, admissions and discharges. |
| 2 | Introduction of a detailed online digital information resource for young people and their families. |

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared valued

We observed safety huddles called a “rapid rundown” which were structured and concise and included members of the multidisciplinary team including medical staff and allied health professionals. Newly registered nurses we spoke with advised us they felt supported by the team.

Inspectors observed examples of good teamwork between the multidisciplinary teams. Staff we were able to speak with were positive about working on the unit and told us they feel able to raise concerns if required. Nursing staff described positive support from the Clinical Nurse Manager who they described as approachable and visible within the unit. However, some staff we spoke with described a lack of visibility of more senior NHS board wide managers. As part of their visit, the Mental Welfare Commission were able to speak with members of the wider multidisciplinary team including medical staff. Please see part one, page seven of this report for further information.

Workforce pressures including recruitment and retention of staff continue to be experienced throughout NHS Scotland. Staff advised inspectors that the number of registered nurses had increased significantly in preparation for the new patient pathway and working model. Senior managers advised that there has been a 93% retention rate for the 22 newly registered nurses employed since 2022. We can see in evidence provided that the Melville Inpatient Unit does not have any current band 5 nursing vacancies.

NHS Lothian utilise an electronic real time staffing tool which calculates staffing requirements based on patient acuity and dependency. Evidence provided by NHS Lothian includes a review of the nursing staff establishment for the Melville Inpatient Unit which includes data from the electronic staffing system. We can see from this that required staffing levels were significantly higher than the previously agreed establishment which had resulted in the high use of agency staff, including registered nurses. Senior managers advised that this data was used when calculating the required increase in nursing establishment.

Supplementary staffing includes substantive staff working additional hours, staff from the NHS board’s staff bank or staff from an external agency. A high use of supplementary staff can have an impact on continuity of care. Staff told inspectors that there had been a significant reduction in the use of band 5 agency staff since the increase in nursing establishment. We can see in evidence provided that in February, March and April 2025, only one shift required agency registered nurse cover. There were a number of shifts covered by

band 5 nurses who are on the NHS Lothian staff bank. During our onsite inspection staff told inspectors that the majority of bank staff are familiar with the unit.

We can also see in evidence provided that there is a 17.54 whole time equivalent band 3 nursing vacancy rate which has resulted in significant use of band 3 supplementary staff. Senior managers advised that 13 of these posts have been recently recruited in to with the remaining posts undergoing recruitment process.

We were also provided with sickness absence data for the unit which shows a continuous reduction in nursing sickness absence from 16.17% in April 2024 to 5.17% for the last quarter. Staff advised that absence management and staff sickness rates had improved since the increase in charge nurses and the implementation of two nursing teams.

We asked staff how skill mix would be maintained due to the significant numbers of new staff including newly registered nurses. Staff told us that the Melville unit has an establishment of six band 6 charge nurses. One band 6 would be rostered onto each shift including nights, to ensure senior nursing oversight. We were also advised that the staff are split into two teams within the unit, Clover and Thistle. Each team has three band 6 charge nurses who support staff including holding one to one meetings every 4-6 weeks and supporting with absence management. Inspectors were also told that staff meetings are held every alternate Thursday and that these include any themes from incident reports or complaints.

On the alternate Thursdays continuing professional development sessions are held. We were provided with timetables for these sessions which have included updates on arts therapies, child protection, managing concerns and update on the units eating disorders standard operating procedure. Continuing professional development enables staff to learn and develop throughout their career as well as ensuring staff are using evidence-based practice. Inspectors had the opportunity to speak to several newly registered nurses during our onsite inspection who advised that they felt well supported to carry out their role in the unit.

Part of the Child and Adolescent Mental Health Nurse Consultant role includes facilitation of learning for newly registered staff including the development of an induction programme. All newly registered nurses also have a clinical skills passport. As discussed in domain 1, nursing staff including newly registered nursing staff are supported by the quality improvement team to produce a quality improvement project as part of their induction. We attended a showcase meeting for the most recent quality improvement projects which included projects to reduce the use of restraint during administration of artificial nutrition via nasogastric tube and the introduction of Melville Unit community meetings between staff and young people. We found the showcase to be informative with a good focus on improving patient care and experience. Community meetings will be discussed further in domain 6 of this report.

Staff told inspectors of recent opportunities for nursing staff to gain experience of working in other areas for short placements. We can see in evidence provided that these are optional with available opportunities including the Accident and Emergency Department at the Royal Hospital for Children and Young People, Regional Eating Disorder Unit at St John's Hospital and Child and Adolescent Intellectual Disability Team.

Staff appraisals are essential to support and enable staff to feel valued and support their development. We asked NHS Lothian for completed appraisal rates for the staff in the Melville unit and can see that as of March 2025 67% of staff had an appraisal completed. We discussed this with senior managers who advised that appraisal rates had risen to 73% in May and that there had been a number of new staff which could reflect on the percentage as they won't yet be due an appraisal.

As part of this inspection, we asked NHS Lothian to provide evidence of all incidents reported by staff from the Melville Inpatient Unit through their incident reporting system for the six months prior to this inspection. Several of these incidents related to violence and aggression towards staff from patients. We were able to observe one young person's documentation for the management of violence and aggression which was clear and well documented. We asked senior managers what support was in place for staff who had been involved in incidents of violence and aggression. We were advised that staff would be supported by senior members of the team and other services such as the 'Here 4 U' service which is the confidential support service for all NHS Lothian staff. Additional health and wellbeing support for Melville Inpatient Unit staff includes 'work well' facilitator drop-in sessions. These provide a safe and confidential space where staff can discuss and access support for any issues that may be impacting their wellbeing. Staff also told inspectors of regular reflective practice and debrief with the psychology team.

Staff told inspectors of focused support being provided to health care support workers in response to feedback that they felt overwhelmed and did not have access to restorative supervision. Evidence provided includes the timetable for these sessions which were twice monthly at first and now monthly. We did not have opportunity during our onsite inspection to discuss with staff if these had been beneficial.

We can see in evidence provided that managing violence and aggression training compliance for nursing staff is 78.84% in the Melville Unit including high level restraint. We can also see that the majority of the remaining staff have been booked on to complete the training and staff told inspectors of further training supported by the Central Management and Aggression team. Senior managers also advised that three members of staff are receiving training to become inhouse managing violence and aggression trainers.

Personal alarms are available for staff who work within the Melville Inpatient Unit to enable staff to summon help quickly in an emergency. Senior managers advised us that if these are activated that the Royal Hospital for Children & Young People Hospital security receive a notification and will respond when able but on occasions may be unable to if responding to another incident. We observed one incident report submitted where a planned restraint for treatment had been commenced when another incident occurred and there were not enough staff trained in high level restraint to respond. We raised this with senior managers who were aware of the incident and advised that security staff had been unable to respond due to availability. Learning from this incident included assessment of acuity and dependency of the unit and escalation to REAS coordinating charge nurse for staffing support if required. A requirement has been given to support improvement in this area.

We observed staff requesting staffing support for planned restraint for treatment during the REAS wide staffing huddle. In another incident report it was documented that two alarms

had been activated at the same time and when one alarm was deactivated it also switched off the second alarm. We raised this with senior managers who advised they would review this.

Staff told inspectors that clinical pauses and debrief sessions were utilised within the unit. We were provided with the debrief flow chart which identifies how staff can request immediate or complex admission debriefs. This documents the members of the debrief team which includes, clinical nurse manager, clinical psychologist, senior occupational therapist and nurse consultant. Staff also advised that debrief sessions can be in the form of complex admission case reviews. We can see in documentation in submitted incident reports that these have included reviews being led by other regional child and adolescent mental health inpatient services. The reviews have also included support and advice from specialist mental health services such as the CAMHS community Meadows Child and Adolescent Trauma team.

The Child and Adolescent Mental Health Services speciality sits within NHS Lothian Royal Edinburgh Hospital and Associated Services (REAS) management and governance structure. This provides a wide range of mental health specialities at both the Royal Edinburgh Hospital and St John's Hospital at Livingston. As part of this inspection, we were able to attend two of the 1pm REAS staffing huddles attended by The Melville Inpatient Unit. We observed these were open and transparent providing a real time overview of the staffing within REAS inpatient services. Staffing for the Melville unit was discussed at both meetings including acuity and dependency and possible mitigations such as redeployment of staff who have high level restraint training to ensure adequate cover. Senior managers appeared to be responsive to risks and concerns raised by staff during the safety huddles we attended.

In addition to the wider REAS huddles, the Melville Inpatient Unit holds a unit based rapid rundown safety brief at 09:00 every morning. Inspectors were able to attend two of these meetings during our onsite inspection. We observed that the meeting was thorough, inclusive, person-centred, structured and concise with safety risks highlighted. There was good multidisciplinary representation including allied health professionals, medical staff and discharge coordinator.

The meeting included a brief handover of each young person's care including safety points such as level of observation and if a potential ligature or absconce risk. It was also discussed if any young people were attending school that day or had any multidisciplinary team meetings or planned passes. This included a young person who was going home on a weekend pass. The number of young people who required nutrition via a nasogastric tube was also discussed as well as any potential admissions. Nutrition via nasogastric tube will be discussed further later in this report.

We observed there is a whiteboard in the office where the rapid rundown takes place which includes information relating to each young person including safety information, who their key worker is and if they are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. Staff advised that this board is updated daily.

Medication reviews were discussed during the rapid rundown including a required change of medication prescription. We asked staff how physical health needs of the young people are

monitored and were advised that the responsible medical officer for the unit has overall responsibility with support from the psychiatric medical team.

Evidence provided includes NHS Lothian Standard Operating Procedures for Shift Leadership and Clinical Handover Between Shifts for Services Managed by REAS. This describes the nursing leadership expected for each shift including allocation of a registered nurse as a shift lead. This role includes effective use of resources, planning and prioritisation of workload and promotion of safety. Inspectors observed there was a shift lead in place and roles were allocated on a whiteboard throughout the day. These included mealtime support, recording of physical observations and medication administration.

We asked staff what processes were in place if a young person becomes physically unwell. We were advised that in hours the medical staff within the unit would assess the young person and out of hours the on call medical team would be contacted. In the case of a medical emergency the staff would call 2222 for immediate response. The 2222 number is an emergency number used within NHS hospitals which connects to the switchboard to activate an emergency response. We asked for staff training compliance for paediatric basic life support training, this training provides staff with the skills to respond to life-threatening emergencies until medical help arrives. NHS Lothian explained that currently 86% of staff working within the Melville Unit hold a current certificate in basic life support.

The Quality Network for Inpatient (CAMHS) Standards for Services (Royal College of Psychiatrists) standard (2.3.3) documents that all medical and registered nursing staff that administer rapid tranquillisation should complete Intermediate Life Support training. Intermediate life support training builds upon basic life support training including airway management. During our onsite inspection nursing staff advised that all registered nurses were being booked onto the intermediate life support training. This was confirmed at our virtual discussion with NHS Lothian senior managers who advised that dates for training were currently being booked. A requirement has been given to support improvement in this area.

Evidence provided includes the NHS Lothian Guidance on Management of Acute Behavioural Disturbance in Adolescent (12-17yrs) Psychiatric inpatients. This is a guideline for the treatment of acute behavioural disturbance which includes the algorithm for intramuscular treatment of acute behavioural disturbance. This provides guidance on the required frequency of physical observation recording post administration. It also advises that if a young person declines to have their observations recorded, that staff should observe for following signs, high temperature, respiratory depression and over sedation and medical help should be sought if any concerns. We did not see any submitted incident reports relating to adverse effects from the administration of intramuscular medication for the treatment of acute behavioural disturbance.

Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 documents when treatment may legally be given to patients who are not capable of consenting to treatment. As part of their visit to the Melville Inpatient Unit the Mental Welfare Commission reviewed young peoples' care records in relation to the legal authorization of treatment. Please see part one page seven of this report for further information. NHS Lothian guidance on the management of acute behavioural disturbance in adolescents' documents that the

administration of intramuscular medication for acute behavioural disturbance should only be used in urgent situations where other measures such as oral medication or de-escalation have been unsuccessful. Within the incident reports submitted in the six months prior to our inspection, approximately 10% relate to the administration of intramuscular medication for reasons including stress and distress, violence and aggression and to prevent significant self-harm. We can also see that it is documented if oral medication had been declined or other types of de-escalation had been tried but were unsuccessful.

Staff advised that out of hours medical cover is provided by the on call team for REAS and that this includes three medical staff including a consultant psychiatrist who are not based onsite at the Melville unit out of hours. Staff advised of a recent incident where they had been unable to contact two of the medical staff who were on call, they had been required to contact the consultant directly.

We can see in evidence returned that an incident report had been submitted where staff had been unable to reach medical staff for two hours as phones were not answered. It is documented that staff contacted the psychiatric consultant successfully and that there was no adverse effect noted at the time to the young person. We asked senior managers for an update on this incident and mitigation to prevent reoccurrence and were told there is a new policy for alerting staff and switchboard if there are gaps in the on call medical rota.

As part of this inspection, we asked NHS Lothian to provide evidence of any adverse event or near miss incidents reported by staff for the six months prior to this inspection. We can see from these reports that incidents relating to attempted self-harm, missed nutrition by nasogastric tube and restraint account for the highest number of reported incidents. These will be discussed later in this report.

Evidence provided includes the NHS Lothian Adverse Event Management Policy. This highlights that adverse events and near misses should be reported and reviewed in a timely and effective manner. In addition, learning from these reviews are identified and shared to inform improvements to services. We can see in evidence provided by NHS Lothian that there are 233 incident reports currently under review. We recognise that a high number of reported incidents/near misses can indicate a culture of transparency and openness in reporting incidents and near misses to enable lessons to be learned and promote a safe delivery of care.

A significant adverse event is an event which caused or could have caused significant harm. Significant adverse event reviews are essential to ensure key learning and reduce the risk of future harm. We can see in evidence provided that there are two significant adverse events under review for the Melville Inpatient Unit. We recognise the commissioning of a significant adverse event review is good practice to ensure lessons are learned and essential to continually improve safe and effective care. However, both these reviews remain open and have not been completed after 14 and 18 months. Senior managers advised that both significant adverse events have had improvement development plans in place and are awaiting approval. This is not in line with Healthcare Improvement Scotland 'A National Framework for Reviewing and Learning from Adverse Events in NHS Scotland' which recommends that significant adverse events are commissioned, reviewed and an improvement development plan are completed in 140 days. NHS Lothian has previously been

given a recommendation to support improvement to align adverse event review timeframes in line with suggested guidance.

We asked senior managers for an update on the open incident reports and what processes are in place for the review of any reported incidents to mitigate the risk of potential harm. We were advised all the 233 open incident reports are under review and have been allocated to appropriate staff. Senior managers advised that as part of the triage process all newly submitted incident reports are reviewed within 24 hours of submission and assigned to relevant staff for further investigation. We were also advised that the number of open incidents are discussed at the Melville Unit monthly senior management team meetings. We can also see that incident report reviews are part of the REAS monthly charge nurse governance report template.

Evidence provided includes NHS Lothian Performance Management CAMHS Staff Governance Scorecard. This shows that there were no overdue incident reports in the holding area for April 2025. However, it also documents that of the 209 incidents being reviewed that 208 were overdue completion. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 2	
3	Staff we spoke with were positive about working on the unit and newly registered nurses told us they feel supported by the team.
4	The use of data from an electronic real time staffing tool to review and increase nursing establishment based on acuity and dependency.
5	Availability of regular reflective practice and debrief sessions for staff with the psychology team.
6	Complex case reviews include peer support from other regional child and adolescent mental health units and specialities.
7	Daily Melville Inpatient Unit safety huddles “rapid reviews” were person- centred, structured and concise with good multidisciplinary team representation.

Requirements

Domain 2	
1	NHS Lothian must ensure enough staff are on duty who are trained in restraint to respond to staff personal alarms at all times.
2	NHS Lothian must ensure all staff who administer rapid tranquilisation have completed intermediate life support training.
3	NHS Lothian must ensure timely review and implementation of lessons learned from reported incidents including significant adverse events.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

We observed positive interactions between staff and patients including during group activities which nursing and occupational therapy staff took part in. However, we observed that not all documentation was completed consistently, and cleaning products were not always stored securely.

Where able our inspections are observational to reduce the impact on the young people and staff caring for them. Inspectors therefore spent time observing care and interactions between staff and patients including group activities. We observed positive interactions between staff and young people and the young people appeared to respond well to staff and the activities taking place.

The provision of meaningful activity on mental health wards is said to increase social connectedness, improve psychological wellbeing and is essential to promote wellbeing and recovery. Staff told us that the unit does not have an activities coordinator but does have an occupational therapist Monday-Friday. There is also a music and art therapist. Staff advised that previously the unit had two occupational therapists enabling seven day cover for activities provision. However, currently nursing staff are required to coordinate activities at the weekend.

Senior managers advised that allied healthcare provision including occupational therapy is being reviewed as part of the options appraisal for the new model of care and patient pathway. Evidence provided included the Melville inpatient timetable, which included aromatherapy, sign language group and upcycling sewing. Inspectors observed that activities were discussed at the rapid rundowns, these included a young person having music therapy and a visit from a professional footballer to play football in the outside area. We talked with two young people who told us that they particularly enjoyed the visits by the Therapet dogs during the week but that weekends could be boring.

NHS Lothian utilises a digital auditing system for managing quality, risk and compliance which enables staff to input audit data online, see real time results and track compliance. A mental health care plan audit was carried out in March 2025, we can see from this that only 74% of young people had a completed activities plan and that these had only been reviewed in the past seven days in 35% of care plan. A requirement has been given to support improvement in this area.

We were able to speak with two parents of young people who were being cared for in the unit. Both parents told us that they were grateful and pleased for the care provided to their children. They also told us that staff strived to maintain dignity for all young people who were experiencing stress and distress including those who had witnessed any episodes. However, they felt that it could cause further distress for the young people if they are required to move to another area of the unit during this time. Symptoms of stress and distress can include agitation, anxiety and aggression.

We asked senior managers what support was available for young people who witnessed episodes of stress and distress who advised that staff would provide support informally as no

formal process was in place. However, a quality improvement project is due to commence for the introduction of patient debriefs.

The parents we spoke with also advised that they felt originally that communication could be improved. This included inconsistent communication in relation to meal plans for the young people which parents told us had resulted in them not being followed consistently and also in relation to communication regarding young people's pass plans. However, parents told us that after raising with staff that this had improved. A pass is when a young person has planned leave from the ward such as for an activity or to go on home leave. We received mixed feedback in relation to the patient admission process on to the ward, with one parent advising that they had not received a welcome pack for three to four days. We were also advised that actions and mitigations which included restrictions that may be placed on the young people while being cared for in the unit had not been communicated on admission. We can see in evidence provided that there have been 17 complaints received by the Melville Inpatient Unit over the past two years. Senior managers advised that several of these highlighted issues relating to communication. A requirement has been given to support improvement in this area.

We asked senior managers what actions have been put in place in relation to complaints regarding communication. We were told that a series of meetings had been held with members of the multidisciplinary team in relation to communication with a follow up meeting planned for August. We were also advised that the AMBIT model (Adaptive Mentalization – Based Integrative Treatment) has been introduced. This is a framework designed to support teams in developing systems of help for vulnerable people. Senior managers advised that lessons learned from complaints are shared with the multidisciplinary team including any actions and learning.

Both parents highlighted that they felt there was a lack of frequency of psychological therapy. We raised this with senior managers who advised that there is currently a vacant consultant clinical psychologist post which is currently under recruitment. The vacant post is currently cross covered by support from psychology services across all Tier 4 services including the child and adolescent mental health services assertive outreach team.

Parents also told us that they felt that current allied health professional provision including occupational therapy, physiotherapy and dietitian provision was insufficient which had an impact on meal plans and activities. Staff told us that physiotherapy input has to be requested via referral to the Royal Edinburgh Hospital. As previously discussed, senior managers advised that allied health professional provision is being reviewed as part of the options appraisal for the new model of care and patient pathway.

Staff and parents told inspectors that the unit has a parents/carers support group with psychology and social work support which meets weekly. One parent we spoke with had been to the support group and described it as very helpful. Nursing staff also advised that there is a weekly contact session between the young person's key worker and family/carer. We observed that there was an information leaflet in reception advising of the family and carer support group as well as being included in the Melville Inpatient Unit welcome information resource. Staff also told us of the family and carers bulletin. These bulletins

inform family and carers of any new staff as well as sharing information such as parent volunteers.

Both parents we spoke with said they felt more could be done to support parents including a way of being able to provide feedback or ask questions that were not urgent. As discussed earlier in this report the newly introduced electronic resource includes the link to NHS Lothian patient experience team which is a central point for receiving patient feedback. However, during our virtual discussion senior managers explained that whilst feedback is discussed with parents that there is currently no process for parents to provide direct feedback to the Melville inpatient service. A recommendation has been given to support improvement in this area.

Staff told inspectors that on admission an early care planning meeting is completed within the first seven days of admission which is then followed by scheduled weekly multidisciplinary team meetings. These include clinical staff, the young person and their family/carers and any other members of the team who are involved in the young person's care including the patient coordinator.

Whilst our safe delivery of care inspections are mainly observational, we may at times require access to documentation to ensure inspectors are able to triangulate observations of care. Where this is required, inspectors will make every effort to avoid disruption to staff delivering care. NHS Lothian utilises electronic patient care records including care plans and risk assessments.

We were able to review a small number of care records. The Mental Health (Care and Treatment) (Scotland) Act 2003 emphasises patient rights, participation in decision-making, and person-centred care. The majority of care plans we reviewed were comprehensive and linked to clinical notes. Documentation in relation to restraint use for nutrition by artificial means via nasogastric tube was clear with patient preferences around meal support and when artificial nutrition via nasogastric tube was part of the plan. Person-centred strategies to reduce distress following this was also documented as was restraint and when this is necessary. We also observed that the use of seclusion was documented clearly, including the time seclusion started and ended. Restraint and seclusion will be discussed further in domain 6 of this report.

Despite risks being recorded in care plans we observed that not all risk assessments were consistently completed with some having a date of most recent update but no documentation of what the update was. Others had dates on entries and when risk was updated/changed but these were not consistently completed.

We also observed that a Waterlow Score had been recorded for one young person that required monitoring of pressure areas to observe skin integrity. A Waterlow Score is a risk assessment tool used to assess a person's risk of developing pressure ulcers. It considers various factors including body mass index and nutrition. However, there was no further documentation of staff conducting checks of the young people's skin integrity. We raised this with staff who advised that young people may often decline skin check. However, we did not see any documentation to say that the young person had declined. We also observed

documentation relating to falls risk. However, a specific care plan to support this care need did not appear to be in place.

Evidence provided includes the mental health care plan audit for the Melville Inpatient Unit for the period March 2025 to June 2025. We can see from this that over 95% of care plans had plans for both mental and physical health completed. However, only 22% of physical health care plans and 41% of mental health care plans were reviewed within seven days.

During our onsite inspection staff told us that the results of the audits are e-mailed to staff and shared at the Thursday staff meetings and can also be discussed with individual staff at their one to one meetings. We discussed gaps we had observed in patient care documentation with senior managers during our onsite inspection who advised that new electronic mental health care plans had been introduced recently and that two clinical educators have been appointed to roll out further training to staff. A requirement has been given to support improvement in this area.

Weekly multidisciplinary team meetings are held with the young person and members of the multidisciplinary team involved in their care. Staff told us the young person is provided with a feedback sheet prior to their multidisciplinary team meeting to enable them to write down any questions they may have in preparation for the meeting. This can also be used if the young person does not want to attend the meeting in person. It includes summary of the week (what the young person feels went well and did not go so well and why). When arrangements are made for the young person to leave the unit on a pass the feedback sheet has the option for them to describe any challenges they faced. We were also advised by staff that the outcomes of the meetings can be provided as an accessible, easy read version of the outcomes of the meeting if required.

Staff told inspectors that historically, nursing staff attendance at multidisciplinary team meetings had been variable due to staffing levels and high use of supplementary staff. However, staff advised that this had improved and that a timetable of the meetings including which nursing staff were to attend were in place. We were also advised that the patient coordinator would attend the multidisciplinary meetings. We observed that it was handed over that any weekly meetings for the day were handed over at the rapid rundown meetings.

The paediatric early warning score (PEWS) and adult national early warning score 2 (NEWS2) are systems that measure physiological parameters such as heart rate and respiratory rate to improve the detection and response to people who are at risk or have become more unwell. Staff advised that the Melville Inpatient Unit records PEWS or NEWS2 scores depending on the age of the young person and that these are recorded on the young person's electronic record. We were able to observe a completed PEWS on the electronic system and this was completed and up to date. Submitted incident reports include one where staff had not recorded PEWS/NEWS due to the acuity within the unit with several young people requiring continuous interventions. It is documented in the incident form that there was no known harm to the young people from this. Learning and mitigating actions included the shift leader allocating the recording of NEWS2/PEWS to a member of staff. During our onsite inspection we observed that a staff member was allocated who was responsible for recording physical observations.

We were provided with the weekly audit of the completion of NEWS2/PEWS from February to March. This showed a variation in compliance from 50% for the week of the 3 February and 3 March and 75% for the 31 March to 80 or 100% for the remaining weeks. It is documented on the audit that there did not appear to be a reason for the missed observations with the action to ensure staff document the reason for missed recording such as if the young person is off the unit or declines.

A significant number of incident reports submitted in the six months prior to our inspection relate to staff having to intervene to prevent young people from harming themselves including attempts to use ligatures. Annual ligature risk assessments are part of an ongoing programme of assurance within NHS hospitals to reduce the number of incidences of self-harm or suicide by identifying potential ligature points and the controls and mitigations in place to reduce identified risks. We were provided with NHS Lothian Standard Operating Procedures for Environmental Ligature Point Inspections and Risk assessments for all clinical Areas within REAS. This describes the actions to be undertaken when carrying out environmental ligature point inspections and risk assessments. Staff advised inspectors that the environmental ligature risk assessment for the unit is completed annually.

We were provided with the Melville Unit Environmental Ligature Point Inspection document dated 12 December 2024 which identifies potential ligature points. Documented control measures include the main bedroom doors having alarms which are activated if any weight is placed on them. We asked senior managers what processes are in place for regular maintenance and testing of the bedroom door alarms. We were advised that the doors have a six monthly planned preventative maintenance. The doors are monitored remotely and if the alarm is activated any potential damage to the door is assessed. Other control measures include the completion of clinical risk assessments, continuous intervention if clinically indicated and environmental checks.

We observed that a number of reported incidents related to young people utilising a specific area of the environment to be less visible to staff. We raised this with senior managers during our virtual discussion who advised that this is utilised by some young people to provide comfort when experiencing stress and distress. However, senior managers also advised that the area was not currently on the environmental risk register but should be added. A requirement has been given to support improvement in this area.

We asked senior managers for an update on incidents submitted as evidence relating to ligatures which documents that care plans were in place and risk highlighted at the rapid review safety brief. However, it also documents that in one instance that a risk assessment had not been completed. A requirement has been given to support improvement in this area.

The Melville Unit Environmental Ligature Point Inspection document highlights any potential ligature anchor points including any caused by damage and wear and tear to the environment. We discussed this with senior managers who advised that continuous interventions would be considered to mitigate risk if a young person was assessed at being at risk of self-harm. We were also advised that any wear and tear should be reported when noted and documented in the ligature action log. However, we were also advised that this had not been consistently done. We also observed a whiteboard in one bedroom that was

peeling from the wall causing a sharp edge. We raised this at the time of the inspection and the room was not in use at the time. A requirement has been given to support improvement in this area.

Inspectors observed that it was highlighted at the rapid rundown which young people have been assessed as at risk of ligatures. The location of the ligature cutters and anti-barricade equipment was also highlighted. The anti-barricade door system enables staff to be able to open bedroom doors from the outside even if a barricade has been used inside.

The National Institute for Health and Care Excellence (NICE) defines self-harm as intentional self poisoning or injury, irrespective of the apparent purpose. Scotland's Self Harm Strategy and Action Plan (2023-27) highlights that self harm is complex and varies widely from individual to individual and can serve a variety of functions. These can include a form of self-punishment, compulsive or habitual behaviour and distraction from distressing emotions. It also documents that self harm can enable people to regulate emotion, provide release or comfort and restore calm.

As previously discussed, we observed a significant amount of incident reports in relation to self-harm, including the use of restraint to prevent or stop self harm. We raised this during our virtual discussion with senior managers including what training staff receive in relation to the prevention of self harm. We were advised that although there is in house training that it is not currently part of mandatory training for the Melville Inpatient Unit staff. A recommendation has been given to support improvement in this area.

NICE guidelines discuss harm minimisation strategies when a person is engaged in ongoing treatment but is not yet in a position to resist the urge to self-harm. Harm minimisation is an approach that accepts a persons continued urge to self-harm whilst aiming to keep long term damage and frequency of injury to a minimum. It highlights that harm minimisation strategies should only be considered in certain circumstances including to reduce the severity and/or recurrence of injury, as part of overall approach to ongoing care and after being discussed with the person and their family and multidisciplinary team. Senior managers discussed recognition of self soothing and that staff will assess this on a one to one basis with intervention as required. It is documented in a number of incident reports that staff have intervened as per care plans including when restraint has been used due to risk of significant self harm. It is also documented that various approaches had been tried prior to restraint being used such as verbal redirection but that these had been unsuccessful.

The number of reported incidents relating to self-harm vary over the six months prior to our inspection. We are aware that a rise in reported incidents may be attributed to the acuity and dependency of the young people on the unit at the time. We can see from documentation in incident reports that it appears staff responded appropriately and intervened, including escalating for immediate medical help and further assessment when required.

We were provided with NHS Lothian Draft Standard Operating Procedure for Continuous Interventions for REAS Inpatient Mental Health Services. Senior managers advised that this is currently being reviewed by the REAS corporate management team in preparation for ratification. The operating procedure was developed in accordance with Healthcare

Improvement Scotland guidance 'From Observation to Intervention.' This aims to support mental health practitioners to move away from the traditional practice of enhanced observations and work towards a patient centred, responsive proactive care. More information can be found at Healthcare Improvement Scotland - From Observation to Intervention.

The standard operating procedure for the practice of continuous intervention highlights the differing levels including general and continuous intervention with general being the level of care all patients should receive, including therapeutic and meaningful interventions. Continuous is an escalated level of intervention which may be required when a young person requires the continuous presence of staff to support them including if they are at risk to themselves or others. A clinical pause may also be utilised if a young person becomes more unwell to review and assess if continuous interventions should be commenced. Continuous interventions should be as least restrictive as possible and only put in place as a last resort. If commenced, it should be documented in the young person's care plan including the proximity of staff required. A number of incident reports submitted as evidence relating to self-harm document that continuous interventions were commenced or recommenced in response to the submitted incident.

The continuous intervention operating procedure documents that a dedicated nurse should have a knowledge of all patients whereabouts at all times. During our onsite inspection we observed that there was an allocated nurse carrying out this role and that staff were present in the communal areas at all times. We observed that staff completed half hourly minimum checks on young people who were not in the communal area which was recorded and documented. Further sporadic checks out with the 30 minutes were also carried out. It was handed over at the rapid rundowns that no young people were receiving continuous interventions during the time of our onsite inspection. The operating procedure also highlights that staff should use trauma informed practice when undertaking continuous interventions. Trauma informed practice includes recognising where people are affected by trauma and responding in ways that prevent further harm. We asked NHS Lothian what training staff received in relation to trauma informed practice who advised that in person training is being rolled out across child and adolescent mental health services.

Staff told us of ongoing damage to a set of doors at the entry to the unit that despite being swipe access if kicked or pushed hard enough could be forcibly opened allowing exit from the inpatient unit. Staff advised that the doors had been fixed several times as they were restricted access doors rather than secure doors but that they were still able to be forced. This risk has been highlighted on the NHS Lothian Risk Register and documents the risk of young people absconding from the unit due to doors being forced open. A risk register is used by NHS boards to systematically identify, assess and manage risks.

We can see from the risk register entry that the risk was opened in September 2022 and last reviewed in May 2025. Controls in place to mitigate risk includes staff communication in relation to the risk of the doors being forced and maintenance of doors after any forced opening. Staff we spoke with advised that maintenance respond quickly to check the integrity of the doors after they have been forced but that this is not a long term solution. We can see from entries in the risk register that the magnets on the door had been replaced

with stronger ones but that they could still be forced open. We raised this with senior managers who advised that a short life working group had been developed in January 2025 in response to ongoing issues with the doors. The group meets every two weeks and monitors and progresses all outstanding works. Membership of the group includes senior managers, representatives from the Royal Infirmary of Edinburgh facilities team, REAS health and safety and fire officer. Senior managers advised that new doors are now being manufactured that are of the same specification as the secure doors at the Royal Edinburgh Hospital and will therefore not be able to be forced open. A requirement has been given to support improvement in this area.

Incident reports submitted as evidence include several where young people have managed to force the doors and leave the inpatient unit. We did not see any incident reports where this had resulted in harm to young people. However, a member of staff had injured themselves when trying to follow a young person who had forced the doors open. We asked staff what mitigations were in place to maintain staff and patient safety until the doors could be fitted and were advised that young people had risk assessments carried out in relation to risk of absconding. We observed that risk of absconsion was discussed at the daily rapid review.

Inspectors observed that medication is stored in patient pods in a clean utility room, we observed that these pods were locked as were the medication cupboards. We observed that the treatment and utility rooms were clean and uncluttered, and the resuscitation trolley had been checked daily.

Standard infection control precautions such as linen, waste and sharps management minimise the risk of cross infection and must be consistently practiced by all staff. We observed good compliance with the management of waste. Waste and used linen were stored in a locked area waiting for uplift. The majority of sharps bins were labelled in line with guidance, with one exception in the treatment room which did not have a temporary closure in place. Temporary closures prevent needles and sharps from protruding from the boxes or falling out if a box is dropped. A requirement has been given to support improvement in this area.

NHS boards are required to have water safety systems in place for the control and management of risks posed by waterborne organisms that may cause disease. Inspectors observed domestic staff running taps in a bedroom that was not in use. Domestic staff told us they have sufficient supplies to clean effectively and have a cleaning schedule that includes daily water flushing for all taps, including those not in use. We were provided with two weeks of water flushing and cleaning logs for the Melville Inpatient Unit and we can see that the majority of these were completed well including documentation for reason why a room could not be cleaned such as young person sleeping. Staff advised that the domestic supervisor reviews and signs the domestic schedule of work records however, the supervisor signature box was not signed in the two weeks of records provided.

On the first day of our onsite inspection, we noted that the domestic service room within the ward was unlocked and therefore cleaning products including chlorine-based cleaning products were not stored securely. Whilst the cupboard was out with the Melville Inpatient Unit it could be accessed if young people left the unit or by young people attending the day

unit. This is not in line with the Control of Substances Hazardous to Health Regulations (2002) and are harmful if ingested. We raised this immediately with domestic staff and senior managers and the cupboard was locked straight away. We checked the cupboard throughout the rest of the inspection, and it remained locked. Senior managers advised that they would discuss with the domestic supervisor to ensure domestic staff are aware of the importance of keeping the cupboard locked. A requirement has been given to support improvement in this area.

During the first day of our inspection, we also found an office door unlocked which enabled access to a pair of scissors. We also observed an electrical cable from a catering trolley and broken toaster in the young person’s dining room. We raised these with staff and senior managers who advised they would review the area immediately.

We did not observe any obstruction to fire exits and staff and hospital managers advised us that there are two patient trolleys and a number of available wheelchairs to ensure safe and timely evacuation if required. The most recent fire safety training figures from March 2025 show that 86% of staff have completed fire training.

Areas of good practice

Domain 4.1	
8	We observed positive interactions between staff and young people.
9	Visits from players from professional football teams to play football with young people.
10	Young people told us they particularly enjoyed visits from the Therapet dogs.
11	Medications were stored securely.

Recommendations

Domain 4.1	
1	NHS Lothian should consider providing a way for parents, carers and young people to provide feedback directly to the Melville Inpatient Unit.
2	NHS Lothian should consider adding self harm prevention training to mandatory training for Melville Inpatient Unit staff.

Requirements

Domain 4.1

4	NHS Lothian must ensure meaningful activity is consistently provided, including evenings and weekends and that activity plans are completed and updated in care plans.
5	NHS Lothian must ensure effective communication with families and young people including care planning, meal plans, passes and any restrictions put in place.
6	NHS Lothian must ensure that all documentation is accurately and consistently completed and reviewed. This includes activity plans, nasogastric bolus charts, and risk assessments.
7	NHS Lothian must ensure all environmental risks are identified, and risk assessed to mitigate potential risks arising from the physical environment.
8	NHS Lothian must ensure the care environment is consistently maintained to ensure staff and patient safety including timely reporting of maintenance requests.
9	NHS Lothian must ensure the safe disposal of sharps.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

A new staffing establishment has been put into place this has increased the nursing establishment of both registered nurses and band 3 healthcare support workers.

Workforce data provided by NHS Lothian includes the vacancy rates for the Melville Inpatient Unit for nursing, medical, psychology and allied health professional staff. We can see from this that there is a consultant psychiatrist and psychologist vacancy plus one band 5 occupational therapy vacancy. As previously discussed, senior managers advised that ongoing recruitment was in place for a psychiatric consultant and psychologist.

The multidisciplinary team for the Melville Inpatient Unit includes nursing staff, psychiatric medical staff, psychology staff and allied health professional staff including occupational therapy, dietetics and music and art therapist. As previously discussed, senior managers advised that work was still ongoing in relation to the new proposed clinical model including provision of allied health professional support. Staff advised that the nursing team included registered mental health nurses as well as registered learning disability and paediatric nurses.

The unit was fully staffed during the days of our onsite inspection with 12 staff on the day shift and seven on the night shift. Senior managers advised that there were no agency staff on the days of our onsite inspection and that whilst there had been shifts sent to NHS Lothian nurse bank that these had been covered by Melville Inpatient Unit staff.

Whilst we observed the use of a real time electronic staffing template and discussion of acuity and dependency and mitigation of risk at the REAS 1pm staffing huddle, there was minimal representation from other members of the multidisciplinary team. However, we

observed good representation of the multidisciplinary team at the daily rapid reviews on the Melville Inpatient Unit including allied health professional and medical staff.

Time to lead is a legislative requirement under the Health and Care (Staffing) (Scotland) Act (2019). This is to enable clinical leaders to ensure they have protected time and resource to ensure appropriate staffing alongside other professional duties to provide the delivery of safe, high quality and person-centred healthcare. Staff we spoke with during our onsite visit told us they felt they had adequate time to lead and that the introduction of the two ward teams had helped to reduce sickness absence and increase regular staff one to one. However, we were unable to talk with the senior charge nurse for the unit as they were not on duty.

As previously discussed, senior managers advised that there had been an agreed increase in the nursing establishment of both registered nurses and band 3 health care support workers, with 13 band 3 staff recently recruited into post and ongoing recruitment for band 3 and band 4 staff to complete establishment. As previously discussed, NHS Lothian utilised data from the live time electronic staffing system to calculate the required increase in nursing establishment. This and staff support and health and wellbeing are discussed further in domain 2 of this report.

The Health and Care (Staffing) (Scotland) Act 2019 stipulates that health boards have a duty to follow the Common Staffing Method. This is a multifaceted triangulated approach which includes the completion of a speciality staffing level tool and a professional judgement tool concurrently run to support NHS boards to ensure appropriate staffing. Whilst we recognise that real time data has been utilised to support decisions regarding safe staffing for the Melville Inpatient Unit, a staffing level tool run has not been completed in the past 12 months and this is not in line with the Duty12IJ of the Health and Care (Staffing) (Scotland) Act and therefore a requirement has been given to support improvement in this area.

Requirement

Domain 4.3

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| 1 | NHS Lothian must ensure completion of the staffing level tool as part of the common staffing method. |
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Domain 6 – Dignity and respect

Quality 6.1 – Dignity and respect

We observed positive and respectful interactions between staff and young people. However, evidence provided highlighted that it was not always documented if young people or families were involved in their care planning.

Inspectors observed positive interactions between staff and young people especially during group activities.

Staff told us that there should be three one to one meetings with young people and their key workers each week. We were also advised that young people are involved in their assessment, care planning, and reviews and that it will be documented if the young person declines or doesn't engage. Family members/carers are also involved if the young person gives consent and has been assessed at having capacity to do so. As previously discussed, evidence provided includes the mental health care plan audit tool for the Melville Inpatient Unit from March-June 2025. We can see in this that there was only documented evidence of young people's involvement in 70.4% of care plans and family/ carer involvement in 80.4%. We can also see that evidence of three weekly one to ones were only documented in 46.4% of care records. A requirement has been given to support improvement in this area.

Staff told inspectors that all young people admitted to the Melville Inpatient Unit are provided with a 'What Matters to Me' resource to enable young people to be involved in their care planning and delivery of care. It includes sections where the young person's care team is documented, information about the young person, communication passport and what goals the young person would like to achieve whilst in hospital. In the records we were able to review we observed that the "What Matters to Me" resource had been completed, or it was documented that the young person had declined to be involved.

Scottish Child and Adolescent Mental Health Services have reported an unprecedented increase in the number and severity of young people presenting with eating disorders since the start of the COVID-19 pandemic. More information can be found at Eating Disorders in Scotland | Scottish Parliament.

Eating disorders are serious mental health conditions and include several categories including, anorexia nervosa, bulimia nervosa and binge eating. Eating disorders can affect people of all ages but are most typically present in adolescents. They are serious conditions which can be potentially life threatening. The Scottish Government National Review of Eating Disorders Services Review Summary Recommendations (March 2021) documents that eating disorders have the highest mortality of all mental health illnesses.

We were provided with the Melville Inpatient Unit (IPU) Treatment of an Eating Disorder Standard Operating Procedure. The purpose of which is documented as being to standardise assessment, treatment and care of young people with an eating disorder. It includes the initial admission process including physical assessment such as blood tests and recording of electrocardiogram and prescription of vitamin and mineral supplements. Initial nursing team responsibilities are also documented including commencement of the young person's initial meal plan which should be reviewed by the dietitian within one day of admission or on the

first working day after a weekend or public holiday. It is documented that the dietitian will prescribe a meal plan following initial review to reestablish a regular eating pattern.

The Melville Inpatient Unit Families and Carers Quick Guide documents that mealtimes are “protected” time for young people to eat together. If a young person has been admitted with an eating disorder, a therapeutic intervention for meal support will be provided by the nursing team. It is further highlighted that families/carers are requested not to visit at mealtimes unless they are providing meal support which will be discussed at the young person’s care planning meeting. It is highlighted in the Melville Inpatient Unit (IPU) Treatment of an Eating Disorder Standard Operating Procedure that the delivery of meal support is a priority intervention to support young people to develop an intake that supports recovery. During our onsite inspection we observed that on each shift nursing staff were allocated to provide meal support to the young people and that nursing staff are provided with meal support training as part of their role. We can see in evidence provided that 16 staff completed meal support training during 2024. Senior managers advised that the meal plan training is one off training and does not require regular update. Inspectors did not observe a mealtime during this inspection due to this being a protected time and part of therapeutic intervention for some young people.

We were provided with the draft Melville Inpatient Unit (IPU) – Treatment of an Eating Disorder Requiring Nutrition by Artificial Means via a Nasogastric Tube Standard Operating Procedure. It describes that if a young person’s nutritional need cannot be met or medical stabilisation has become difficult to achieve via oral intake that nutrition via nasogastric tube may be required. It also documents that physical restraint may be required to deliver artificial nutrition via nasogastric tube if adequate oral intake is refused. It further highlights that nutrition via artificial means should be a last resort and should only be undertaken following a comprehensive risk assessment of physical, nutritional and psychological factors.

Reasons to consider nutrition via nasogastric tube recorded in the standard operating policy for the Melville Inpatient Unit are aligned with the Royal College of Psychiatrists Medical Emergencies in Eating Disorders: Guidance on Recognition and Management, further information can be found at Medical Emergencies in Eating Disorders. This guidance highlights that eating disorders can present with life threatening emergencies and that weight loss in children and adolescents is often more acute due to lower body fat stores. The guidance highlights that some people may resist weight gain by any means and compulsory treatment under the relevant legislation may be necessary especially in cases where the level of malnutrition is life threatening. This may require insertion of a nasogastric tube against the patient’s will by staff trained in restraint techniques. Restraint will be discussed further, later in this report.

We can see in incident reports submitted as evidence that several relate to young people missing nutrition by nasogastric tube for a variety of reasons. This includes acuity within the unit at the time the nutrition was due to be administered. Therefore, there were not enough available staff to provide safe restraint and also being unable to obtain an aspirate from the nasogastric tube. Aspirate should always be obtained from the nasogastric tube prior to commencing nutrition to ensure correct placement in the stomach. We discussed this with senior managers who advised that if nutrition is missed that a clinical pause will be

undertaken to assess if the young person is clinically stable enough to wait until the next day or if the nutrition should still be given that day. In some instances, the time for administration of the nutrition may be changed to support acuity, we were also advised that the dietitian would be involved in any decisions to change plans.

The Melville Inpatient Unit utilise NHS Lothian Department of Nutrition and Dietetics Nasogastric Bolus Chart. This is a document which is completed for all episodes of artificial nutrition via nasogastric tube and includes but is not exhaustive of volume of feed given, if restraint used, type and length of time and staff involved. We were provided with copies of completed bolus charts from March, April and May 2025. We can see from these that whilst the PH of the aspirate is recorded in the majority of entries that there are some gaps. We asked senior managers what processes are in place who advised that whilst there is no current audit process that this is being taken forward as part of the draft Melville Inpatient Unit Nutrition by Artificial Means Standard Operating Procedure. A requirement has been given to support improvement in this area.

Incident reports submitted as evidence include two describing the use of the communal area for the administration of nutrition via nasogastric tube due to staff being unable to safely escort the young person to the treatment rooms. This is not in line with the draft Melville Inpatient Unit Nutrition by Artificial Means Standard Operating Procedure which documents that the treatment room should be used. We asked senior managers how the young person's privacy and dignity would be maintained in this instance who advised that if it would be unsafe to move the young person from the communal area that other young people would be moved to other areas such as the dining room. Inspectors observed that it was discussed at the rapid rundown if young people had not been able to meet their nutritional needs orally as per care plan and would therefore require nutrition via nasogastric tube.

Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 documents when treatment may legally be given to patients who are not capable to consent to treatment. The Mental Welfare Commission Good Practice Guide for Nutrition by Artificial Means highlights that the Mental Health (Care and Treatment) (Scotland) Act 2003 makes specific reference to the provision of nutrition by artificial means in the absence of consent, more information can be found at Mental Welfare Commission for Scotland Nutrition by Artificial Means. SIGN guidelines for eating disorders documents that "clinicians should consider whether the Mental Health (Care and Treatment) (Scotland) Act 2003 needs to be invoked when a patient (of any age) declines treatment: There may be a responsibility to provide compulsory treatment if there is a risk to the person's life or to prevent significant deterioration to health and wellbeing. SIGN 164 Eating disorders Revised August 2022. Scottish Intercollegiate Guidelines Network (SIGN) aim to improve the quality of health care by reducing differences in practice and outcome.

Staff told inspectors that an incident report is submitted for all episodes of physical restraint including those planned for the administration of nutrition via nasogastric tube. We can see in evidence provided that incident reports have been submitted for the use of restraint when administering nutrition by artificial means. We also observed an incident report where there was prolonged restraint due to lack of availability of a specific medication. We asked senior managers for an update on this incident who advised that there is no designated pharmacist

for the Melville Inpatient Unit and that certain medication is not stocked at the Royal Infirmary of Edinburgh and therefore has to be obtained from the Royal Edinburgh Hospital. Currently nursing staff are responsible for routine stock checks and ordering of medication. A member of the pharmacy team from the Royal Edinburgh Hospital completes checks approximately every two months. We were also advised that dedicated pharmacy provision is being reviewed as part of the new split site model. A requirement has been given to support improvement in this area

The Mental Welfare Commission highlights that restraint should only be implemented by staff who have been fully trained in the methods of restraint rights, risks and limits to freedom. Physical restraint training supports staff in how to apply restraint techniques safely without causing unnecessary harm or distress to patients. Melville Inpatient Unit staff training compliance for managing violence and aggression including physical restraint are discussed earlier in this report.

The National Institute for Clinical Excellence (NICE) highlights that if face down restraint is utilised that this should be for the shortest time possible. We observed four incident reports submitted as evidence which documented the use of face down restraint to enable the administration of intramuscular medication in response to stress and distress. It is also documented that the restraint was changed from face down to face up once medication had been administered.

During our onsite inspection, the Mental Welfare Commission raised concerns with NHS Lothian in relation to the number of staff involved in the physical restraint of a young person. Senior managers provided an immediate response to these concerns and advised that the correct number of staff as previously agreed by the managing violence and aggression team had been involved in the restraint. Senior managers also told us that not all staff documented as being involved in the restraint were actually physically restraining the young person and that additional staff were in the room to enable staff to rotate during restraint and to administer the nutrition.

Senior managers advised they would review violence and aggression training records and ask the REAS managing violence and aggression training team to provide further support and review of restraint techniques. During our onsite inspection and in response to concerns raised by the Mental Welfare Commission, the team leader from the Corporate Clinical Education Management of Aggression Team observed a restraint procedure being carried out. The team advised that staff had managed the restraint well and that the techniques they observed had been risk assessed and approved. They were also able to advise on any equipment required to enable restraint for different types of furniture used within the unit and that they would prioritise any additional training for Melville Inpatient Unit staff. We asked senior managers what processes are in place to monitor if restraint is appropriate and adheres to guidance. We were advised that details of restraint are reported via the electronic incident reporting system which are reviewed and actioned and that reports can be run from the system.

Senior managers also advised that they would review the documentation used to record staff involved in restraint for the administration of nutrition via nasogastric tube to clarify

the roles of the staff involved such as staff administering nutrition and staff actually involved in the restraint.

One of the quality improvement initiatives currently being implemented by staff is aimed to reduce the amount of restraint required when administering nutrition via nasogastric tube. Quality improvement methodology has been utilised to gain understanding of contributing factors which include the environment, staff, equipment and methods. Whilst this is at an early stage of development data has been collected to provide a baseline which will be used to assess impact once tests of change are implemented.

Other incident reports we reviewed include several where young people were placed in seclusion. The Commissions use of seclusion good practice guide documents that seclusion should only be considered when the person is a significant danger to others and the situation cannot be managed by any other means. The Melville Inpatient Unit was built with a designated seclusion room. However, staff advised that this room was not appropriate, was never used and we observed it was being used for storage. Staff advised that if seclusion was required this would take place either in the young person's room or the intensive nursing suite. The intensive nursing suite is an area through double doors at the far end of the inpatient unit.

Staff advised that although bedroom doors can be locked from the outside that they can always be opened from inside the room. Staff also explained that NHS Lothian Standard Operating Procedure for the use of Seclusion defines differing levels of seclusion. This includes level 1 seclusion which is when a person is secluded alone in a room either by locking the door or preventing them from leaving by holding the door shut, standing in the doorway or instructing them not to leave. Level 2 seclusion is when staff remain with the person in seclusion or place restrictions on the persons physical environment with the intention of keeping them separate from others.

Staff told us that if seclusion takes place that this would be escalated via the coordinating charge nurse for REAS and also the psychiatric medical team including the on call doctor out of hours. We were able to observe patient care records for a young person who had been assessed as requiring seclusion due to violence and aggression. Seclusion was documented in the anticipatory care and crisis plan and start and finish times of the period of seclusion had been recorded. During our onsite inspection no patients within the Melville Inpatient Unit were in seclusion, we did observe during the REAS wide 1pm staffing huddle that patients who had required seclusion in other care areas were highlighted to the senior management team.

Mixed sex accommodation can impact on dignity and personal choice. Whilst the Melville Inpatient Unit does not have any gender specific communal areas all young people have individual bedrooms including en-suite bathrooms to enable privacy. During our onsite inspection we observed that there was always a member of staff in the communal area. Senior managers advised that consideration will be given to gender specific communal areas in the new model of care and patient pathway.

Outdoor spaces can play an important role in patient wellbeing and recovery. We noted that the Melville Inpatient Unit has a secure outdoor space that can be used by young people. We

observed that this space was used occasionally by staff and young people including to play football.

We attended a recent showcase of three quality improvement projects implemented by the Melville Inpatient Unit staff. One of these included the introduction of weekly community meetings for young people and staff to enable them to work together to improve the unit. Some of the outcomes from this have been the involvement of the young people in the environment and decoration and the development of two questions written by young people which were asked at recent staff interviews. We also observed the farewell forest which is a set of trees placed on the wall which young people who are being discharged can add 'leaves' too with messages on. Staff advised that the young people receive the blank leaves in their welcome packs and that they were involved in designing the trees and leaves. We were also provided with the 'Melville meeting' feedback template, this is completed at the weekly meeting and enables young people to highlight "what was good this week and what was not so good". There is also a section for updates and "You said we did".

We received the Quality Network for Inpatient (CAMHS) QNIC report and action plan for the Melville Inpatient Unit internal audit relating to the Royal College of Psychiatry network for inpatient child and adolescent standards. This audit was implemented following the Mental Welfare Commission visit to the unit in 2022. The audit has an action plan that is reviewed and updated throughout the year with the most recent update being March this year.

The action plan includes documentation of areas for improvement relating to questions asked as part of the audit which is based on seven standards. These include environment, staffing and training and information, consent and confidentiality. One of the questions in the audit which is highlighted as still being an area for improvement is to ask staff and young people if they feel safe on the ward. We raised this with senior managers who advised that they used to utilise a patient experience survey but that this has not been completed recently. A requirement has been given to support improvement in this area.

We can also see in the Royal College of Psychiatry Quality Network for Inpatient CAMHS (QNIC) report that there is currently no specific vegan option available for young people. Staff also raised concerns with inspectors during our onsite inspection in relation to lack of available diet for the needs of the specific patient group. This included that there used to be high calorie "snacks" available but that these were no longer provided. We raised this with senior managers who confirmed that there was no available vegan option and that this would be reviewed. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 6	
12	Quality improvement initiative being implemented with the aim to reduce required restraint during the administration of nutrition via nasogastric tube.
13	Introduction of Melville Inpatient Unit community meetings.
14	Use of two interview questions written by young people for recent interviews.

Requirements

Domain 6	
11	NHS Lothian must ensure that young people and their families are involved in planning their care and that this is clearly documented including regular one to ones.
12	NHS Lothian must ensure necessary medication is available in an emergency.
13	NHS Lothian must ensure any outstanding improvements actions highlighted within the Royal College of Psychiatry Quality Network for Inpatient CAMHS (QNIC) internal audit are actioned.
14	NHS Lothian must ensure adequate provision of a full range of dietary options.

Concluding Comments

As noted at the outset, the collaboration of the Commission and Healthcare Improvement Scotland to focus on both the micro level (experience of receiving and delivering care in the context of mental health and incapacity law) and the macro level (systems, leadership and governance) aimed to deliver comprehensive, independent and robust assurance of the unit.

The summary below details both good practice and areas for improvement which will be followed up with the service.

Areas of good practice

The Commission and Healthcare Improvement Scotland observed positive interactions between staff and young people and were told by young people that they felt listened to.

All staff who engaged with us clearly expressed their commitment and passion for working with young people and their desire to support recovery. Staff we spoke with were generally positive about working on the unit and newly registered nurses told us they felt well supported.

Psychology input is viewed very positively and regarded as a valuable contribution to the multidisciplinary team.

Healthcare Improvement Scotland staff attended a showcase of quality improvement initiatives introduced by nursing staff. These included an initiative to aim to reduce the use of restraint required when administering nutrition by artificial means, weekly community meetings for young people and staff and the introduction of an online resource for young people and their families.

Healthcare Improvement Scotland staff observed the Melville Inpatient Unit daily safety huddles (rapid rundowns). These were concise and structured and included members of the wider multidisciplinary team such as dietitians, occupational therapists, patient coordinator and medical staff.

NHS Lothian have utilised their live time staffing tool to calculate required nursing staffing levels resulting in an increase in nursing establishment with good recent recruitment and

retention rates. We also noted and welcomed young people being given the opportunity to contribute questions for interviews for staff as part of the recruitment process.

We were advised that NHS Lothian Child and Adolescent Mental Health Inpatient Services are currently developing a new model of care and patient pathway.

Some of the relatives/carers we spoke with were grateful for care provided. However, they told us they felt that there could be more dietitian and psychology support. All relatives/carers said that they felt that staff were approachable. However, trust and confidence were caveated in terms of some staff being better than others.

Areas for improvement

The practical application and safe use of proportionate restraint as a last resort is a significant issue at the Melville Unit. Based on observation of practice, the impact on young people, the lack of detailed anticipatory care plans, incomplete recording of details post event and completion of the electronic incident reporting system, the approach to restraint in the Melville Unit requires further enquiry and improvement by the service.

Nasogastric tube feeding under restraint requires further enquiry and improvement by the service to ensure best practice is being followed and young people are given every opportunity to retain decision making as per best practice guidelines.

Authority to treat young people should be in accordance with the Mental Health (Care and Treatment) (Scotland) Act 2003. Lawful practice and understanding of roles and responsibilities has yet to be embedded at Melville Inpatient Unit with no evidence of managerial oversight or action progressing following recommendations previously made by the Commission. This is an area which requires further enquiry and improvement by the service.

The issue of multidisciplinary team dynamics has been a long-standing known issue at the Melville Inpatient Unit. Our direct observation and feedback given to us evidence that little progress has been made. This is an area which requires further enquiry and improvement by the service.

There appeared to be a disconnect between what activities were reportedly said to be available and the experience of young people particularly in the evenings and at weekends. Parents reported similarly. Some young people explained that this failure in provision meant they spent too much time thinking their own “thoughts”.

The quality of care planning, associated documentation and inclusion of parents/relatives remain an area that has yet to develop as recommended by the Commission previously.

Communication with young people and their families is an area highlighted for further improvement.

The maintenance of the environment to ensure staff and patient safety.

We are grateful to all those who took the time to engage with us as part of this joint visit/investigation process undertaken by the Commission and Healthcare Improvement Scotland.

Appendix 1 - List of national guidance

The following national standards, guidance and best practice were current at the time of publication. This list is not exhaustive.

- [Allied Health Professions \(AHP\) Standards](#) (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, January 2016)
- [Covert Medication](#) (Mental Welfare Commission, May 2022)
- [Food Fluid and Nutritional Care Standards](#) (Healthcare Improvement Scotland, November 2014)
- [Generic Medical Record Keeping Standards](#) (Royal College of Physicians, November 2009)
- [GIRFEC principles and values - Getting it right for every child](#) (GIRFEC)
- [Health and Care \(Staffing\) \(Scotland\) Act](#) (Scottish Government, 2019)
- [Health and Social Care Standards](#) (Scottish Government, June 2017)
- [Infection Prevention and Control Standards](#) (Healthcare Improvement Scotland, 2022)
- [Mental Health \(Care and Treatment\) \(Scotland\) Act 2003](#) (Scottish Government, 2003)
- [Mental Health Scotland Act 2015](#) (Scottish Government, 2015)
- [National Infection Prevention and Control Manual](#) (NHS National Services Scotland, June 2023)
- [National child protection guidance – Child Protection](#) (Scottish Government, 2023)
- [NMC Record keeping: Guidance for nurses and midwives](#) (Nursing & Midwifery Council, August 2012)
- [Operating Framework: Healthcare Improvement Scotland and Scottish Government](#) (Healthcare Improvement Scotland, November 2022)
- [Person Centred Care Plans](#) (Mental Welfare Commission, August 2019)
- [Person-centred care](#) (Nursing & Midwifery Council, December 2020)
- [Preparation of care plans for people subject to compulsory care and treatment](#) (Mental Welfare Commission, October 2021)

- [Prevention and Management of Pressure Ulcers - Standards](#) (Healthcare Improvement Scotland, October 2020)
- [Professional Guidance on the Administration of Medicines in Healthcare Settings](#) (Royal Pharmaceutical Society and Royal College of Nursing, January 2019)
- [Rights, risks, and limits to freedom](#) (Mental Welfare Commission, March 2021)
- [Scottish Patient Safety Programme SPSP](#) (Healthcare Improvement Scotland)
- [The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives](#) (Nursing & Midwifery Council, October 2018)
- The Quality Assurance System (Healthcare Improvement Scotland, September 2022)
- [The UNCRC Act - UNCRC \(Incorporation\) \(Scotland\) Act 2024](#) (Scottish Government, February 2024)