Mental Welfare Commission for Scotland

Report on announced visit to:

Eden Unit, Royal Cornhill Hospital, Cornhill Road Aberdeen, AB25 2ZH

Date of visit: 7 February 2023

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

The Eden Unit is a specialist eating disorders service based in Royal Cornhill Hospital. The unit accepts referrals from Tayside, Grampian, Highlands, Orkney, Shetland and the Western Isles. There are 10 in-patient beds that provide accommodation for female and male patients. On the day of our visit there were seven patients in the ward, and two patients out on pass.

In addition to the in-patient unit, the service had a day provision programme that provided a step down/step up facility, which supported patients in the community. We were told that the day programme facility was no longer based in the unit, but was in a separate area in the main hospital. There were four spaces on the day programme, which were solely for NHS Grampian patients and we heard how this facility had supported patients as part of discharge planning, or as a resource in order to try and prevent hospital admission.

We last visited this service on 27 November 2019 as part of the Commission's themed visit to eating disorder services across Scotland. Following the publication of the report *Hope for the Future: care, treatment and support for people with eating disorder in Scotland* in September 2020, the Scottish Government announced that eating disorder services would be subject to a national review. At the same time of this national review, Healthcare Improvement Scotland published a new clinical guideline on Eating Disorders, SIGN 164, in January 2022**.** There is ongoing work following on from the national review and the Commission continues to be interested in the outcomes and work from the implementation groups.

On the day of this visit, we wanted to speak with patients, relatives and staff, and to find out how the service was implementing the recommendations from the Commission's themed report. We also wanted to find out if there had been progress made towards the outdoor garden space, as this was highlighted to us on the themed visit.

Who we met with

Prior to the visit, we held a virtual meeting with the senior charge nurse (SCN), consultant psychiatrist and associate specialist doctor.

On the day of the visit, we spoke with all of the above and some of the ward-based nursing staff. We spoke with four patients and reviewed the care of five patients. There were no relatives who wanted to meet or speak to us.

In addition, we made contact with the advocacy service, who had good links to the ward, providing support to the patients when needed.

Commission visitors

Tracey Ferguson, social work officer

Anne Buchanan, nursing officer

What people told us and what we found

We were told that since our last visit the staff team had lost experienced staff, who had left a significant knowledge gap that had created inexperience in the staff team. We heard that due to staffing vacancies, there had been times when the SCN had to be included in the number of registered staff on shift, to ensure continuity and safe delivery of patient care, thus impacting on their senior role. However, we heard that there were two part-time depute posts in place that will support the leadership team moving forward and we heard of the continued efforts to recruit staff to vacant posts. We were told that training new staff can be clinically demanding, however the unit had a strong commitment to ensuring that all staff had the expert knowledge and skills to support patients, and this came across on the day of our visit. There was a real sense of staff commitment to continuous professional development and investment to support new staff to gain the necessary skills, which was positive.

We spoke with patients who had been referred to the unit for specialist care due to the complexity of their diagnoses. Most of the feedback was positive from patients. All patients told us that all staff were caring and approachable, and that they took their time to get to know them. One patient told us that they felt heard and that they were listened to by all of the multidisciplinary staff. Another patient told us that they were grateful to have been in the Eden Unit and would recommend the unit to anyone that needed support with their eating disorder. Some patients told us that they had been to other eating disorder units and their view was that the Eden Unit was far better than any other. Patients described staff as understanding and that they worked with them in a supportive manner. Sometimes a patient may require an increase in the levels of observation due to risks and one patient told us of an occasion where restraint had to be applied, and they felt the intervention was done in a gentle and safe manner, providing the patient with an understanding on why this was required. Where comments were not so favourable, these was around lack of staffing and communication.

Care, treatment, support and participation

Patients who are admitted to the Eden Unit are likely to have many significant health issues that are associated with an eating disorder, combined with the symptoms and behaviours connected to their mental health. The unit had an information leaflet for patients, and we were told that the service had devised a new booklet for patients and families about what to expect when admitted to the unit.

From the patients' files we reviewed, we saw detailed multidisciplinary team (MDT) assessments on admission, and formulation plans that were devised for patients. We found detailed risk assessment and risk management plans that were regularly reviewed and updated, where necessary. However, we did speak to the SCN about a patient's plan that had been updated and risk category changed, but there was no evidence in the document about the reasons for this change.

We found a good deal of information contained in patient's one-to-one discussions with nursing staff, which evidenced patient involvement and participation.

We were pleased to see examples of detailed, person-centred care plans that were reviewed regularly; however, some of the care plan evaluations lacked detail, therefore it was difficult to see the patients' progress from admission. We found some care plans with multiple

updates added to the original care plan. We discussed this further with the SCN, as we felt those care plans required to be re-written. We found that patients' participation in care planning was good, with patients' goals documented, and some patients had signed their care plans. We found an entry in one file, where it was recorded that the evaluation could not be completed with the patient, as they were on pass. We were told that the nursing staff devised the care plans and the MDT contributed to the care planning, although we found the way in which the care plans were written lacked detail regarding the whole MDT approach to patients care and treatment.

In reviewing files, we found that patients had input from a variety of specialists such as dietetics, psychology, occupational therapy (OT), physiotherapy, nurse therapy. Details of psychological therapy sessions were contained in the patients' files, however this detail did not translate into the patients' care plans. We suggested to the SCN and clinical team that they need to consider ensuring this information was reflected in the care plans.

The SCN told us that care plans were updated and evaluated by the nursing staff at weekends; however, we were concerned that if this is only done at weekends, and patients are on pass, meaningful evaluations, with patient participation, may not be as collaborative. We had a discussion about the role of named nurse in the unit and the SCN agreed to have further discussions with the staff team regarding this.

Recommendation 1:
Managers should carry out an audit of the care plans to ensure they fully reflect the specific detail of MDT involvement/intervention with individuals working towards their care goals and that the reviews and evaluations are consistent across all care plans and maximise patient participation.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:
https://www.mwcscot.org.uk/node/1203

Multidisciplinary team (MDT)

The unit was staffed by a multidisciplinary team (MDT) from various professional backgrounds that offered individually tailored treatment programmes from specialist staff, who were specifically trained in eating disorders.

Staff working in a specialist eating disorder unit are expected to undergo specific training in order to develop specific knowledge and skills to support individuals with an eating disorder. We heard from the SCN and clinical team about recent ongoing challenges in staff recruitment and retention in the unit, and heard about the continued proactive efforts to recruit staff. We recognise that recruitment of nurses is a national issue.

We were told that each patient admitted to the unit was provided with an individually tailored treatment plan, where they were supported by various members of the MDT, which provided a collaborative and holistic approach, supporting patients with their physical and psychological wellbeing. We saw detailed formulations completed in the first few weeks of admission that identified outcomes and plans as part of the patient's recovery. We saw where

therapeutic approaches were identified, and provided to patients, such as dialectical behavioural therapy, mentalization based treatment, interpersonal therapy, family based therapy, and art therapy. Although some patient care plans identified psychological therapies, other interventions and treatments including practical skills, such as meal portioning and meal preparation were also included. We found the ethos of the unit very clearly focussed on the holistic support for the individual, in order to improve outcomes as part of their overall recovery.

We noted that there was good input with regards to physical health care input and monitoring and that the service had protocols in place for patients who required to be transferred from another part of the region to the unit. The consultant told us that they would expect the home area to carry out the necessary physical health checks prior to transfer and where a patient required admission to a medical ward in their home area, that the specialist eating disorder consultant would be responsible for this. We had recently been made aware of a case where a patient's transfer was not as smooth as it should have been and this may be due to the fact that there is no current specialist eating disorder consultant in the patient's home area of Tayside. This was a concern and the service agreed to have discussions in the regional eating disorder meeting, as this may impact on a patients follow up care, when discharged. The Commission visitors have agreed to alert the relevant Commission practitioner of the situation.

We were told that the service had an anorexia nervosa protocol in place for the management of patients with severe and acute anorexia nervosa, who required to be admitted to a medical ward, either prior to or during admission to the Eden Unit. The MDT told us that the unit had a clear admission pathway and referral protocol with ward 104 in Aberdeen Royal Infirmary, where patients who were required to be admitted due to their acute medical needs; the referral would be initiated by the NHS Grampian consultant. The Commission's themed visit report found that criteria for hospital admission was often decided by a person's body mass index (BMI), however the NHS Grampian protocol that was in place had no physical criteria or BMI cut off levels, which we felt was positive, and that care and treatment was more focused on the individual needs of patients.

The MDT meeting was held weekly, where all members of the MDT attended and discussed patient's progress. We were told that each patient met with a nurse prior to the meeting to discuss any requests. These requests were then taken forward to the meeting and the nurse fed back to the patient after the MDT meeting. We were told by staff that this could be an anxious day for patients as they were aware that the meeting was being held and were waiting to see if their requests had been approved. Referrals to the service were also discussed in this meeting.

We spoke to nursing staff who attended this meeting and they told us that this meeting could be a lengthy, due to the discussion of all referrals to the service. We heard that it could be difficult to determine which patient to feedback to first, as patients can be anxious and wanted to know the outcome.

We found the records of MDT meetings to be comprehensive and person-centred, with recordings of clear outcomes. We noted that particular attention was given to ensure that there was contact with relatives, and home care teams, of those patients who lived out-of-area. We found that the service had a clear transition pathway in place that provided a person-centred approach between outpatients, day patients and inpatients.

We also found minutes of discharge planning meetings where patients and relatives, if appropriate, would attend, along with staff from the home team. We saw that there were well-established links formed with home areas.

Use of mental health and incapacity legislation

On the day of our visit, seven of the nine patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The patients we met with during our visit had a good understanding of their detained status, where they were subject to detention under the Mental Health Act. We found that all documentation relating to the Mental Health Act was in place and up-to-date.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place, where required, and corresponded to the medication being prescribed. We found that all T2/T3 certificates had been completed by the responsible medical officer were available and up-to-date. We saw that some patients had a T2 and T3 certificate in place and we had further discussions with the clinicians regarding these.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we saw this recorded in the patient's file.

Rights and restrictions

We found that the ward has good links with advocacy service and that patients were being supported by this service.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. No patients had been made a specified person on the day of our visit.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

When we are reviewing patient files we looked for copies of advance statements. The term 'advance statement' refers to written statements made under ss274 and 276 of the Mental Health Act, and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We saw some copies of advance statements in patient files.

The unit had a display board on the wall in the corridor that provided information to patients about their rights and where they could access support. We also saw correspondence and detailed information in patient files that they had received to inform them of their detention status and rights under the Mental Health Act.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

Patients were able to tell us about the groups and the one-to-one sessions with therapists that they were involved in as part of their recovery. We were told that nursing, occupational therapy, physiotherapy staff offer groups and one-to-one sessions that are held on the ward. We saw that the ward had a timetable of therapeutic activities in place and that patients were provided with a range of psychological therapies tailored to meet their needs; this was evidenced in patients' files. Staff told us that their working environment provided them with learning opportunities to develop enhanced knowledge and skills. We were able to get a sense that this was a service that reflected on practice and had developed a positive learning culture, even with recent challenges in recruitment and retention.

The physical environment

The Eden Unit had six single rooms that all had individual bathrooms, and the rooms provided ample storage for patients' belongings. There was a dormitory that had capacity for four patients, with a shared bathroom, and similar furniture for storage. There was also access to a larger bathroom on the unit. The unit had shared areas in which to socialise with other patients. There was a small living room with a TV, sofas, and reading corner, and a larger communal area where post-meal supervision took place. We saw that the unit had recently purchased new seating for this area. There was an arts and crafts area and we saw some recent art work displayed on the wall. Staff told us that a number of patients liked to draw and paint as they found it relaxing and therapeutic, and patients confirmed that this was the case.

There was a kitchen in the unit, where portioning and meal preparation took place. The dining area was attached, where patients attended for all meals and snacks. The SCN told us that the urn was not working and that the staff had to boil kettles; it was hoped that this would be repaired soon, although a part had had to be ordered. Patients and staff were unable to access fresh tap water due to the cold water tap not working. We were told that bottled water had to be purchased in the interim. We were advised that this has been escalated to senior managers and contractors were involved. We will seek an update from the SCN regarding this.

There was a garden attached to the ward which patients were able to spend time in when physically stable. On our last visit, we heard that there had been fundraising events, organised by carers, to support the development of the outdoor garden area. This funding had been with hospital managers for some time and on our last visit, we saw the development plans for this work. Unfortunately, we were told that there had been no progress regarding this. Understandably, due to the pandemic this may have been further delayed, however we were

told that before the pandemic there had been no progress. Both staff and patients told us that the garden area did not provide a therapeutic outdoor space.

Recommendation 2:
Managers must ensure that the garden area is developed according to the approved plans.

Summary of recommendations

Recommendation 1:
Managers should carry out an audit of the care plans to ensure they fully reflect the specific detail of MDT involvement/intervention with individuals working towards their care goals and that the reviews and evaluations are consistent across all care plans and maximise patient participation.

Recommendation 2:
Managers must ensure that the garden area is developed according to the approved plans.

Service response to recommendations

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

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

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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