Mental Welfare Commission for Scotland

Report on announced visit to: Eden Unit, Royal Cornhill Hospital, Cornhill Road, Aberdeen, AB25 2ZH

Date of visit: 5 March 2024

Where we visited

Eden Unit is a 10-bedded specialist eating disorder unit based in Royal Cornhill Hospital. On the day of our visit, there were five individuals in the ward. The unit admits individuals of mixed gender, and the accommodation provides a mix of single bedrooms and dormitory accommodation.

The unit accepts referrals from Tayside, Grampian, Highlands, Orkney, Shetland, and the Western Isles. The eating disorder service also provides a day provision programme that supports individuals in the community. There were four spaces on the day programme, which were solely for NHS Grampian individuals, and we heard about how this facility had supported individuals as part of discharge planning and prevention to hospital admission.

We last visited this service in February 2023 on an announced visit and made recommendations on the outdoor space and the auditing of care plans. The response we received from the service was an action plan that provided details as to how the service was going to meet the recommendations.

On the day of this visit, we wanted to follow up on the previous recommendations and look at individuals' experience of being in the unit.

Who we met with

We met with three people and reviewed the care records of four people.

We spoke with the service manager, the nurse manager, senior charge nurse, consultant psychiatrists, and ward-based staff.

In addition, we contacted the advocacy service and met with the pharmacist.

Commission visitors

Tracey Ferguson, social work officer

Kathleen Liddell, social work officer

What people told us and what we found

Feedback from individuals about their experience on the unit was mixed. One individual described staff as "good, supportive and approachable", while another told us that on the night shift there were often staff that they did not know, which caused them anxiety. One individual told us that they felt bored at times, as there was not much to do, whilst another told us about the activities they participated in.

All individuals told us that they felt involved in their care and treatment, and of the reasons for admission. Where an individual told us that they did not want to be in the unit, they were able to tell us about their rights and of the support available from advocacy services. Individuals told us about other professionals involved in their care and treatment such as occupational therapy (OT) and dietetics; they were able to tell us who their keyworker was. One individual told us that they found the routine in the ward helpful and that this aided their recovery.

The unit had devised a booklet for individuals and families about what to expect when admitted to the unit, which was positive to see. The SCN told us that visitors were welcomed, out with the protected mealtimes.

Care, treatment, support and participation

Individuals who are admitted to Eden Unit are likely to have many significant, complex health issues associated with an eating disorder, combined with the symptoms and behaviours connected to their mental health; we found this to be the case on the day of our visit.

We were able to see from reviewing files that individuals had input from a variety of specialists, such as dietetics, psychology, occupational therapy, physiotherapy, and nurse therapy.

Care records

Most care notes continued to be in paper files, however daily recordings were held on the electronic system TRAKCare. The unit had a mixture of paper and electronic documentation, and some professionals had their own system, therefore it was difficult to navigate an individual's record due to the different systems in place. The unit also kept an additional separate file for Mental Health Act documentation. We heard from managers that they had concerns about the different recording systems and of the risks of not having all records held in one place, similar to what we found on the day. We continue to hear about the plans for NHS Grampian to move to a new electronic system in the future and were told that there were ongoing pilot sites in the hospital that are testing the system, however there is no planned date for this to be rolled out to all services as yet. This will be an opportunity for all records to become integrated.

Recommendation 1:
Managers must review the current recording systems to ensure that all professionals in the service adopt a consistent approach to recording, whilst awaiting a new integrated electronic system.

We found good evidence of regular one-to-one sessions between individuals and staff that was recorded in the files, which were detailed and meaningful, as were the daily nursing entries recorded in the notes.

Care plans

We were aware of new care planning documentation that was being rolled out across Royal Cornhill Hospital. This had been developed from a working group that had been established to improve care planning documentation and processes across NHS Grampian. We saw the new documentation and were able to see from reviewing files that the nursing staff were in the process of changing over all the care plans to this new format.

We saw evidence of detailed holistic care plans, with regular reviews taking place that had evidence of individual participation, however, we found one care plan that lacked detail and was not person-centred; we discussed this with managers. We also found that there was variation in the evaluations that were carried out. Some were detailed, while others had minimal recording. We reviewed a detailed continuous intervention care plan, with evidence of ongoing review.

In terms of engagement and participation, we saw that some individuals had signed their care pans, and others recorded that the individual did not wish to participate or sign their care plan. The process of engaging the individual in the care planning process had improved since our last visit, which we were pleased to see. On previous visits to Eden Unit, the standard of care plans was good; however, on this visit we still found the way in which the care plans were written lacked detail regarding the whole multidisciplinary (MDT) approach to each individual's care and treatment.

We asked about the audit process that was in place, however, were told that due to the group devising a new audit form, this had been put on hold, but that the pilot has now been completed and an audit programme was being put in place. Therefore, the recommendation that we made on last year's visit regarding the importance of regular care plan audits still stands.

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

Recommendation 2:
Managers should carry out regular audit of the care plans to ensure they fully reflect the specific detail of MDT involvement/intervention with individuals towards their care goals and that the reviews and evaluations are consistent across all care plans.

Multidisciplinary team (MDT)

Staff working in a specialist eating disorder unit are expected to undergo specific training to develop specific knowledge and skills to support individuals with an eating disorder. We heard from the SCN and clinical team about the continued proactive efforts to recruit staff since our last visit and that the leadership team felt that they were in a more positive staffing situation, with only two band 5 (staff nurse) vacancies. Although the SCN had recently left post, we were told that this post had already been recruited to.

The unit is supported by a full MDT with various professional backgrounds that offer individually tailored treatment programmes delivered by specialist staff, who were specifically

trained in eating disorders. Managers told us that a music therapist had recently joined the team and they had begun to work with individuals.

We were told that all persons admitted to the unit were provided with an individualised tailored treatment plan, supported by various members of the MDT that provided a collaborative and holistic approach, supporting individuals 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 person's recovery. The therapeutic approaches consisted of dialectical behavioural therapy, mentalization-based treatment, interpersonal therapy, family-based therapy, and art therapy. Other interventions and treatments including practical skills, such as meal portioning and meal preparation. We found that there was a strong ethos in the unit that was very focused on ensuring the holistic support for the individual, in order to improve outcomes as part of their overall recovery, and this is similar to what we found on last year's visit.

We found that there was good input with regards to physical health care input and monitoring and that the service had protocols in place for individuals who required to be transferred to the unit from another part of the region. The consultant psychiatrist told us that they would expect the home area to carry out the necessary physical health checks prior to transfer, and where a person required admission to a medical ward in their home area, the specialist eating disorder consultant would be responsible for this. We are aware that there continues to be no current specialist eating disorder consultant in the home area of Tayside, which we were told was an ongoing concern, particularly around discharge planning and community follow up. The consultant psychiatrist at the Eden Unit was continuing to link in with the local community mental health teams in that area.

We were told that the service had a protocol in place for anorexia nervosa protocol and for the management of individuals 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, where the referral would be initiated by the NHS Grampian consultant and those individuals who required to be admitted due to their acute medical needs would go to Ward 104 in Aberdeen Royal Infirmary. The Commission's themed visit report on eating disorders found that criteria for hospital admission was often decided by a person's body mass index (BMI); the protocol that NHS Grampian has in place has no physical criteria or BMI cut off levels, which we felt was a positive approach to care and treatment, and one that was more focused on the individual's needs.

The MDT meeting is held weekly. All members of the MDT attend, including pharmacy and an individual's progress is discussed. We were told that each individual has a meeting with their nurse prior to the MDT meeting, to discuss any specific requests for this meeting. These requests were then taken forward to the meeting and the nurse would then provide feedback to the individual after the MDT meeting. We saw details of the individual's requests in the MDT record in the care files. Referrals to other parts of the service were also discussed in this meeting and this meeting also included individuals who were part of the day programme.

We found the records of MDT meetings to be comprehensive and person-centred, with clear outcomes recorded. We noted that particular attention was paid in ensuring contact with relatives, and home care teams, for those who lived out of area. We saw that the service had a good transition pathway in place that provided a personalised approach to individuals who were receiving their care in the unit, in the community or attending the day programme.

We also found that where relevant, there were minutes of discharge planning meetings, liaison meetings with the home team and where individuals and relatives, if appropriate, would attend, along with staff from the home team. We saw that there were good links formed with home areas, and we heard this from staff, which was positive.

Use of mental health and incapacity legislation

On the day of the visit, three people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

All documentation relating to the Mental Health Act and the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), including certificates around capacity to consent to treatment were easy to locate and were kept with the prescription Kardex. We were aware that there had been audits carried out by pharmacy across the Royal Cornhill site and that a good practice guide was produced to support staff. We were pleased to see a copy of this was in each file.

The individuals 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.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, 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 all T2, T3s and T4s (emergency treatment) certificates in place, and consent for all T2 certificates was signed and dated. We discussed one case with the pharmacist where there was a T2 and T3 in place, and the same medication was listed on both certificates. Whilst it can be appropriate for someone to have both a T2 and a T3 certificate in place, the same treatment cannot be listed on both, and capacity and consent should be assessed for each treatment offered.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where an individual had nominated a named person, we found copies of these in the care record.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. Where this was required, we found a section 47 certificate in place, which was in order and there was a specific treatment plan.

We were also pleased to find detailed section 76 Mental Health Act care plans that had been completed by the responsible medical officer (RMO).

Rights and restrictions

The door to the unit was locked however, there was no display or policy on the door. We were aware that there was information provided in the admission leaflet about this, and we advised managers that they should display the locked door policy near to the door. Managers told us that NHS Grampian was in the process of reviewing their locked door policy, and agreed that in the meantime, they would display the current one.

We found that the ward had good links with advocacy and the service visited the ward regularly to support individuals. The unit had a display board on the wall in the corridor that provided information to individuals about their rights and where they could access support. We also saw correspondence and detailed information in care records that individuals had received, to inform them of their detention status and their rights under the Mental Health Act.

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 an individual was a specified person in relation to this, and where restrictions are introduced, it is important that the principle of least restriction is applied. There was one individual that was subject to specified person legislation on the day of our visit, but the required paperwork was not in place. We spoke to the consultant psychiatrist on the day of our visit who agreed to attend to this as a matter of urgency.

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

We were aware from speaking to individuals and staff that some individuals' bathroom doors were locked at specific times of the day, usually on admission to the unit. The SCN told us that the locking of a bathroom door would only happen in the en-suite rooms and not the dormitory. We spoke with individuals who were aware of this routine and told us that this was discussed with them on admission and included in their care plans. This information was provided in the information leaflet, and we saw recordings in care plans and the care records of discussions relating to this, that had taken place at the time of admission, and then followed up in MDT meetings.

We had a further discussion with SCN and consultant psychiatrist about individuals' rights where individuals were not detained under the Mental Health Act and were not happy with this level of restriction in place. We were satisfied that there were regular reviews in place of restrictions and that individuals views were sought at various times whether they were detained or informal. We were aware that the unit had recently devised a draft voluntary admission contract for an informal person to sign on admission. The contract outlined the specific restrictions in the unit and how the person could be supported if they were unhappy with such restrictions. The Eden Unit was keen for us to have a look at this document, which we agreed to do and will follow this up with the service.

When we are reviewing patients' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the

Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We did not find any advance statement in files on the day of our visit, however we were told that the unit discusses these with individuals at meetings and on admission, and we found examples of this in the care records.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that individuals have their human rights respected at key points in their treatment.

Activity and occupation

The unit had an activity programme displayed on the wall in the corridor, and we were told that the occupational therapist and physiotherapist delivered most of the group activities on a daily basis. Nursing staff told us that it was beneficial having those professionals dedicate time for activities, as this enabled them to concentrate on the nursing aspects of the individual's care and treatment.

Individuals were able to tell us about the groups and the one-to-one sessions with therapists, and what they were involved in as part of their recovery and how they benefitted from these activities. We saw artwork displayed on the wall in the lounge area that individuals had completed, and we heard from individuals that they found drawing and painting very therapeutic. We saw recording of activities in individual files and recordings where a person had been offered but had declined. Where we heard from individuals that they preferred one-to-one activities, rather than groups, we asked the SCN if the OT would devise an individualised planner initially. We were told that they would however, we did not find this in individual files. We got the impression that more activities were being offered than were being recorded, however this may have been due to different recording systems.

The SCN told us that there were regular community meetings on the unit and there was a book in the lounge area where individuals could make comments and suggestions about specific issues on the ward such as improvements, meetings, activities.

The physical environment

Eden Unit had six single rooms that all had individual bathrooms. Each room had a bed, storage shelves or a wardrobe for individuals to store their belongings. There was a dormitory that had capacity for four individuals, with a shared bathroom, and similar furniture for storage. The dormitory was currently being used for one individual who was on continuous intervention. There was also a larger bathroom in the unit.

The unit had shared areas that supported individuals to socialise and that were used for groups. An area in the communal lounge had been changed to provide a snug area for individuals who wanted some alone time out with their room/bed space. The communal lounge area was the area that individuals used for post-meal supervision.

The unit had purchased new seating and furniture for the lounge area. There was a kitchen in the unit, where portioning and meal preparation took place. The dining area was attached, where individuals attended for all meals and snacks. We were told that some individuals would

cook with staff in this area. We were told that the cooker in the kitchen was not efficient, as it took a long time to heat; we fed this back to managers who agreed to look into this.

We wanted to follow up about the outdoor garden area, as we had been concerned about the lack of progress since our themed visit in 2019. Access to the garden area was via the communal lounge area and we had previously been told that carers had raised funds to support the development of this area, but there had been no progress. Advocacy service had been in contact with the Commission about the lack of progress with this, and individuals had fed this back to us on the day of the visit.

The managers told us that quotes had now been received for the works, and that plans had been drawn up and individuals had been involved with this work. We were pleased to hear that there had been some recent progress, and we will continue to request an update from managers about this.

Any other comments

We gained the impression that this was a service which reflected on practice, developed a positive learning culture, and had a good focus on staff retention and staff wellbeing. The team had created an improved working space for staff in the unit and the SCN told us that the team in the Eden Unit had been nominated for a DAISY award. The DAISY (diseases attacking the immune system) award is a global recognition programme that recognises and celebrates the skilled, compassionate care that nurses deliver daily. We were also told that individual staff members had been nominated for a STAR award, for their outstanding contribution to the delivery to individual care, which was positive to hear.

Summary of recommendations

Recommendation 1:
Managers must review the current recording systems to ensure that all professionals in the service adopt a consistent approach to recording, whilst awaiting a new integrated electronic system.

Recommendation2:
Managers should carry out regular audit of the care plans to ensure they fully reflect the specific detail of MDT involvement/intervention with individuals towards their care goals and that the reviews and evaluations are consistent across all care plans.

Service response to recommendations

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

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

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

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

The Commission visits people in a variety of settings.

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

When we visit:

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

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

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

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

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

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

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

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

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

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