Mental Welfare Commission for Scotland

Report on announced visit to:

The Regional Eating Disorders Unit (REDU), St John’s Hospital, Livingston, EH54 6PP

Date of visit: 10 July 2023

Where we visited

The Regional Eating Disorders Unit (REDU) is a specialist 12-bedded inpatient unit that provides care and treatment for individuals with eating disorders from NHS Lothian, NHS Fife, NHS Forth Valley, and NHS Borders. The unit is supported by a specialist multidisciplinary team offering a blended and comprehensive approach of nursing, medical, occupational, physical, psychological, and dietetic therapies.

Admission to REDU is generally via a referral from the community eating disorder team who have requested a planned admission. Patients and relatives/carers would be provided with information about the unit that includes a video of the environment and what inpatient support is available. However, there are times when admissions are unplanned, when care and treatment is required more urgently.

We last visited this service on 24 January 2019 and made recommendations in relation to specified person's procedures, patients being aware of their rights and developing positive risk-taking strategies.

On the day of this visit, we wanted to follow up on the previous recommendations, meet with patients, staff and relatives/carers, as well as look at the care and treatment being provided on the ward.

Who we met with

We met with and reviewed the care of eight patients, seven of whom we met with in person and one who we reviewed the care notes of. We also met/spoke with two relatives/carers.

We spoke with the service manager (SM), the clinical nurse manager (CNM), the senior charge nurse (SCN), charge nurses, staff nurses, consultant psychiatrist and medical staff.

Commission visitors

Kathleen Liddell, social work officer

Dr Juliet Brock, medical officer

Susan Hynes, nursing officer

What people told us and what we found

Care, treatment, support and participation

Comments from patients and relatives/carers

The patients we met on the day of the visit reported a range of views about their care and treatment in REDU. All the patients we met with told us that the admission from community to inpatient services had been challenging and stressful. The patients were mainly positive about their care and treatment in REDU with the feedback including comments such as "its brilliant", "staff are kind and helpful", "my key nurse is very supportive and offers me regular one-to-one support". All patients were able to identify a member of the clinical team that they had established a positive working relationship with. Many of the patients commented that they liked it when staff engaged in activities such as playing board games with them, and that this helped establish a therapeutic relationship. The patients we met with told us that the food choice and quality in the unit was good.

Most of the patients we met with told us that the staff team had good knowledge and expertise of eating disorders. Many of the patients spoke positively about the weekly multidisciplinary team (MDT) meetings, reporting that they felt their views were listened to during the meeting.

We heard from all the patients that we met with that they found REDU to be a restrictive environment. Six of the patients we met with were voluntary patients however, they told us that the level of restrictions in relation to time off the ward, access to phones and certain areas of the ward (such as their bathroom) were too regimented, restrictive, and at times felt punitive. Patients added that there were inconsistent practices and approaches by staff in relation to the restrictions being applied. We heard that this led to patients feeling unclear about their care plan and risk assessment.

Some patients commented that mealtimes could be particularly difficult. We heard that most of the staff offered patients positive support during and post mealtimes however, we were also told that some staff made negative comments and at times raised their voices during mealtimes, which patients found "distressing" and "triggering".

A few of the patients raised an issue in relation to the use of phones and technology in the ward. Some patients found the restrictions on the use of technology challenging, adding that some staff use their mobile phones in communal areas, which they found "unfair" and "unsupportive".

We heard that community meetings took place in the unit once a week. Most patients were positive about these meetings, as they provided an opportunity for patients to feedback on any issues they had. Other patients felt it was "a tick box exercise" adding that staff rarely attended and there was no way to feedback discussions to staff. It was felt there was no formal process for suggestions made at meetings to be taken forward or actioned.

We spoke with two relatives/carers. The feedback from relatives/carers was mixed however, both agreed that the care and treatment provided to their relative/friend was "excellent", adding that it was clear the MDT had a good level of knowledge and skills on eating disorders. One relative/carer told us that some staff were not very empathetic or compassionate and, at times, they did not feel welcome visiting their friend/family on the ward.

We heard that it was difficult for relatives/cares when their family member did not want them fully involved in their care and treatment. We were pleased to hear that these relatives/carers felt fully supported by the MDT and were provided with an opportunity to meet with the clinical team to offer their views. We were also pleased to hear that the relative/carer had been provided with a wide range of information and support that provided help when caring for an individual with an eating disorder.

The Commission published a themed visit report *Hope for the future: looking at care, treatment and support for people with an eating disorder* (2020). One of the recommendations from this report highlighted the importance of relatives/carers being involved, where appropriate, in a patient's care and being able to access support and information to help provide this support. We were pleased to note that a support group has been developed for carers/relatives to attend. The group runs over six weeks and is online to accommodate the location and other commitments of relatives/carers. The support group has input from each discipline of the MDT, as well as BEAT, an eating disorders organisation. The group offers information and an opportunity to for relatives/carers to ask questions. One of the carers we spoke to had attended the support group. They offered positive feedback and told us that they found it beneficial when supporting their relative.

Nursing care plans

A nursing care plan is a tool that identifies detailed plans of nursing care; effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

The care plans we reviewed were of mixed quality. Most of the care plans were didactic and did not evidence strengths-based goals or outcome-focussed interventions. We found little evidence of person-centred or personalised care. Some patients told us that they felt the care plans were too generic and would have preferred aspects of their care plan to include interventions personalised to their views and outcomes, as well as including how they wished to be communicated with and treated by the MDT. We found many care plans that recorded an intervention to support the patient such as 'use of distraction techniques', however, the care plans lacked detail as to what the specific intervention entailed. Some patients told us about discharge planning, however, we were unable to see evidence of robust discharge planning, including detail in relation to what was required for progression towards discharge.

There was little evidence of patient involvement or participation in the care plan. This was endorsed by patients that we spoke with who told us that they did not have much involvement in the completion or review of their care plan. This concerned us, as the principle of participation allows and encourages patients to be involved in decisions about their care.

We found aspects of the risk assessments to be comprehensive and of a good standard. The risks were clearly recorded with a plan to manage each identified risk. On review, we found that some of the risk factors recorded in the assessments were no longer proportionate to the initial risks on admission. We were concerned that this led to inappropriate levels of restrictions being in place for some patients.

We saw that physical health care needs were being addressed and followed up appropriately by the medical staff. Patients provided positive comments of the management of their physical health care needs.

When we reviewed the care plans, we found that regular reviews had taken place. We did not find all the reviews to include summative evaluations relating to the efficacy of intervention, targeted nursing intervention, or the individuals' progress. We discussed this with the SCN on the day of the visit and recommended that an audit of care plan reviews be carried out. This would ensure that they reflected the work being done with individuals in working towards their care goals and that the reviews were consistent across all care plans.

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 1:
Managers should ensure there is increased patient participation in care planning.

Recommendation 2:
Managers should ensure nursing care plans are person-centred, contain individualised information, reflect the care needs of each person, and identify clear interventions and care goals.

This recommendation was also noted in our last visit report.

Care records

Information on patients' care and treatment was held electronically on TrakCare. We found this easy to navigate.

The care records were recorded on a pre-populated template with headings relevant to the care and treatment of the patients in REDU. We found the quality of information recorded in the case notes to be mainly of a high standard. The case notes we reviewed evidenced person-centred and individualised information, detailing how each patient's day had been and what had been positive or challenging. There was evidence of frequent one-to-one interactions between most of the MDT and patients. We were pleased to find that the case notes included regular communication with relatives/carers and relevant professionals.

It was evident from reviewing care records that the patient group required high levels of care, motivation and support, with each of the MDT involved in providing the care and treatment to patients. We were pleased to note regular reviews of the patients' mental and physical health out with the weekly ward round.

Multidisciplinary team (MDT)

The unit had a broad range of disciplines either based there or accessible to them. In addition to the nursing staff, there was one full time RMO, a part time specialist doctor, a locum speciality doctor, a full-time dietician, dietetic support workers, occupational therapists, and a physiotherapist. The ward psychology post was vacant, although this post had been advertised. While the post has been vacant, psychology support has been provided by the community teams to some patients.

We were pleased to hear that a consultant physician attends the ward at least once a week to review the patients' physical health needs. If any of the patients require increased support for physical health care needs, there is a robust and efficient pathway to transfer patients to a medical ward. Staff from REDU remain involved with the patient during this time and will offer support at meal times, if required.

The MDT meeting is held weekly in the ward, which all the MDT attends. Patients are invited to attend, and most patients told us that they find the meeting positive, as they are able to provide their views about their care and treatment. It was clear that everyone in the MDT was fully involved in the care of patients in REDU.

In addition to the weekly ward round, there is a four-weekly review meeting that the MDT, patients, relatives/carers, and community teams attend. The meeting reviews the patients' care and treatment and considers discharge planning. Not all the patients we met with had attended a review meeting as they had not been an inpatient long enough. The patients who had attended told us that discharge planning was discussed.

Use of mental health and incapacity legislation

On the day of our visit, two patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). The patient we met with during our visit had an understanding of their detained status under the Mental Health Act. For the other detained patient, a review of their file indicated that a curator ad litem had been appointed to safeguard the interests of the patient in proceedings before the Mental Health Tribunal.

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 reviewed the only T3 form that was required. The form had been completed by the responsible medical officer, was up-to-date and recorded authorisation of treatment.

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

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 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. No section 47 forms were required on the day of the visit.

Rights and restrictions

REDU continues to operate a locked door.

In the previous report (2019), the Commission highlighted specific criteria for admission to REDU and recommended that patients should be made aware of their rights and the discussion clearly documented. Staff and patients told us that on admission to REDU, patients are asked to sign a consent form in relation to restrictions being put in place as part of their care and treatment. Examples included consent to the bathroom door being locked, no initial pass time out of the ward, and consent to medication being administered including nasogastric (NG) feeding if the patient does not manage the required nutritional intake. We reviewed the consent form and had concerns that it was overly prescriptive, was not tailored to the needs of the individual, and placed levels of restrictions that were excessive on all patients, particularly informal patients. We were concerned after speaking with patients that they had felt unable to give fully informed consent at the point of their admission, given their high levels of anxiety. Patients also reported they believed their cognitive ability to understand and consent to these restrictions had been negatively impacted by the effects of starvation. We did not see any information for patients relating to the admission process if they did not consent to the restrictions. We found that patients had mixed understanding of their rights as an informal patient.

One informal patient told us that they had not had any pass time off the ward in a four-week period. During discussions with staff about pass time, we were told that it is recommended that patients engage in a full meal plan before pass is authorised. This blanket approach did not appear to be tailored to the individual risk assessment. We found that not all informal patients agreed with this restriction and wanted time off the ward to spend time with family. There was a view from patients that if they did not adhere to the restrictions put in place, they would be discharged from the unit, therefore, some patients felt unable to challenge the restrictions. We also heard from patients that there was an inconsistent approach as to how and when staff implemented restrictions. An example of this was in relation to how patients were supervised when using their bathroom. Patients raised concerns about their right to privacy and dignity during this practice.

On reviewing patient files, we were not satisfied that some of the restrictions in place were proportionate to the risk factors identified in the risk assessment. It was evident from the patient files that there was no regular review that involved a comprehensive and specific discussion with the patients about the restrictions that had been put in place or about their rights as an informal patient. There appeared to be limited flexibility or positive risk-taking strategies in place.

We raised our concerns with the management team in relation to the restrictions placed on patients in the unit. The management team told us, and it is recorded in the patient information booklet, that the restrictions were put in place for approximately two weeks during the initial assessment period. Whilst we understand that initial restrictions may be needed for patient safety and security purposes, we were concerned that by adopting ongoing generalised restrictions, it did not promote a person-centred approach to care and treatment and was not compatible with the core principles of the European Convention on Human Rights. The Commission would expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed. We raised concerns that, given the levels of restrictions in place for some patients, they were in fact detained and would be afforded more safeguards, legal, and human rights under the Mental Health Act. We suggested to SM, CNM and SCN that discussion at the ward round and recording of the patient's consent to restrictions should be implemented as a matter of priority.

When we reviewed patient files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act. An advance statement is written when a person has capacity to make decisions and states how they would like to be treated if they become ill in the future. Health boards have a responsibility for promoting advance statements. We were told that one patient had an advance statement. In discussion with other patients, they reported that they were not aware of advance statements however would be interested in completing one.

Regular advocacy is provided to the unit by the Mental Health Advocacy Project and a specialist eating disorder advocacy worker from the Consultation and Advocacy Promotion Service (CAPS). Patients that spoke to us told us that they had regular contact with advocacy services and had used advocacy support during ward reviews.

We made contact with both services. The Mental Health Advocacy Project provide six weekly sessions to patients on subjects relating to rights, and recently discussed advance statements and named persons. The project also offers collective and individual advocacy to patients in the unit.

CAPS provide a specialist eating disorder worker to the attend unit three times a week. The CAPS worker operates a drop-in service and individual advocacy to patients.

We asked both advocacy services if there were any themes raised by patients regarding rights, care, and treatment in the unit. We were told that issues in relation to a restrictive environment and issues with various staff members' practice were brought up and discussed regularly. Advocacy services continue to offer patients advice and support on their rights.

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

Recommendation 3:
Managers should ensure that the restrictions placed on patients on admission are reviewed regularly and discussions regarding restrictions are clearly documented.

Recommendation 4:
Mangers should ensure that rights based care is delivered to patients and recorded in patient care plans. Managers should ensure that information on rights is visible throughout the ward.

Activity and occupation

Various members of the MDT delivered the activities in the unit. We heard and found evidence of psychological interventions, such as dialectical behaviour therapy and The Decider Skills being offered to patients. Psychoeducation groups such as nutrition and cooking group and dietetics were also regularly on offer. Other activities available included craft groups, board games, jigsaws, and pamper sessions. We heard that regular volunteers attend the ward and offer creative writing and therapet sessions. The patients told us that activities with a more therapeutic and well-being focus were important as many of the groups are nutrition-based.

Patients told us that the groups in the unit tended to take place at the end of the week, meaning that the start of the week had less structure; this led to feelings of boredom and frustration. Patients commented that having the groups over a shorter timeframe in the week could be 'intense' and thought it would be better if the groups were spread across the week. On review of patients' files, we did not find much evidence of consistent structured activity; instead, patients engaged in more informal activities such as crafts, board games, and jigsaws. The Commission's themed visit report (2020) highlighted the importance of engagement in meaningful activity to provide structure to a patients' day, to reduce boredom and frustration and to increase social interaction, improve general well-being and maximise therapeutic benefit.

Recommendation 5:
Managers should ensure that there are structured activities regularly available to patients that have a therapeutic and well-being focus. Managers should ensure that activity participation is recorded and evaluated.

The physical environment

REDU's environment is bright and spacious. There is a hub area in the centre of the ward that patients and staff use. The unit also has a family room that patients can spend time with their relatives/carers. The family room is child-friendly and had various toys for children who maybe be visiting. The dining room and lounge areas were spacious. The lounge had many activities such as board games and crafts and we saw patients and nursing staff engage in these activities during the visit. There was a laundry room and kitchen for patients to access and complete their own laundry and meals if appropriate, and if included in the patients' care plan.

The cleanliness of the unit was of a good standard and the decor well maintained. We were told that the unit had recently been painted and new furniture, including sofas, had been purchased which added to the unit having a homely feel. The SCN told us that the unit is looking to get new artwork for the walls to further promote a welcoming environment.

We were able to view some of the patients' bedrooms. All bedrooms have en-suite facilities and personalisation of patients' rooms was encouraged. We were told that further anti-ligature work is required and as part of this programme, new beds have been purchased for the majority of the patients' bedrooms. The SCN told us that ongoing anti-ligature work is required and the unit is part of the hospital programme to have this work completed.

Patients can access a garden area. The garden was spacious and had seating areas that created a therapeutic space for patients.

Any other comments

We met with various staff members on the day of the visit. All the staff members we spoke to told us that they enjoyed their job, felt part of a supportive team and were committed to providing good patient care. It was evident from speaking with staff they were very skilled and had extensive knowledge of working with patients with an eating disorder. Staff told us that they were offered good support from senior management in the form of regular supervision. In addition to this, staff could attend fortnightly reflective psychology sessions that were beneficial. Staff told us that there are some staff vacancies and at times bank staff are used, however, most of the vacant posts have been filled and the bank staff used are regular staff and have good knowledge of the ward and patient group.

We were told that there has been an increase in admissions of younger patients to the unit. This is mainly due to a rise in the prevalence of eating disorder in Scotland although at times there has been a lack of child and adolescent mental health services (CAMHS) beds available to manage the increased demand on the service. We were pleased to hear that work is currently being undertaken between REDU and CAMHS inpatient services in supporting young people who are transitioning from CAMHS to adult services. The RMO attends regular meetings with CAMHS inpatient services. A pathway is being developed with the focus on supporting young people and their relatives/carers when transitioning into a specialist adult eating disorder inpatient setting.

Summary of recommendations

Recommendation 1:
Managers should ensure there is increased patient participation in care planning.

Recommendation 2:
Managers should ensure nursing care plans are person-centred, contain individualised information, reflect the care needs of each person, and identify clear interventions and care goals. This recommendation was also noted in our last visit report.

Recommendation 3:
Managers should ensure that the restrictions placed on patients on admission are reviewed regularly and discussions regarding restrictions are clearly documented.

Recommendation 4:
Mangers should ensure that rights-based care is delivered to patients and recorded in patient care plans. Managers should ensure that information on rights is visible throughout the ward.

Recommendation 5:
Managers should ensure that there are structured activities regularly available to patients that have a therapeutic and well-being focus. Managers should ensure that activity participation is recorded and evaluated.

Good practice

The Commission's themed visit report (2020) made a recommendation regarding staff working in eating disorder services having access to appropriate levels of training. We were impressed by the level of training that staff in the unit had undertaken and the ongoing commitment of providing staff with specialist eating disorder training. Patients and relatives/carers positively commented on the specialist skill set and knowledge staff in the unit had and the positive outcomes for their care and treatment.

The SCN told us that two staff have recently qualified in a clinical decision making course and further staff member will complete this qualification imminently. We were also pleased to hear that a number of health care support staff have been encouraged to progress to further education and complete their nursing qualification. The majority of the staff who have completed their nursing qualification have returned to work in the unit, which is credit to the level of support offered to staff by the management team.

We were advised that an online video, which provides patients and their carers information about REDU has been developed since our last visit in 2019. There has been positive feedback from patients, carers, and referrers about this. The video allows insight into the care that can be provided and the environment in which patients will be cared for. The video can be accessed by the following link:
https://vimeo.com/721439154

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk

Mental Welfare Commission 2023