Mental Welfare Commission for Scotland

Report on unannounced visit to:
St John's Hospital, The Regional Eating Disorder Unit (REDU), Livingston, EH54 6PP

Date of visit: 12 May 2026

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

The Regional Eating Disorders Unit (REDU) is a specialist, 12-bedded 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 (MDT) of nursing, medical, occupational therapy (OT), physical health, psychology and dietetics who offer a blended and comprehensive approach.

Admission to REDU is generally via a referral from the community eating disorder teams who have requested a planned admission. Individuals and relatives/carers are provided with information about the unit prior to admission; this includes a video of the environment and what inpatient support is available.

There are times when admissions are unplanned, when care and treatment is required more urgently.

On the day of our visit, there were 11 individuals on the unit and one vacant bed.

We last visited this service in March 2025 on an unannounced visit and made recommendations in relation to improving the quality and consistency of person-centred care planning, ensuring restrictions were lawful, proportionate, regularly reviewed and clearly documented, strengthening rights-based care and participation in decision-making, and improving the recording and review of enhanced observation and continuous intervention practices.

The response we received from the service reported that a quality improvement project relating to mental health person-centred care planning was underway, with regular auditing by the senior charge nurse (SCN) to improve the quality and consistency of care plans and strengthen collaboration with individuals, families, carers and the wider MDT.

The service advised that restrictions continued to be reviewed weekly in MDT meetings, with increased focus on documenting rationale, consent, and discussions regarding restrictions, particularly for people admitted to the unit informally. The service also reported that discussions in relation to a person's rights would continue throughout admission and be recorded in care planning documentation, while enhanced observation and continuous intervention practices would be supported through updated documentation processes, staff training, regular review and audit.

In relation to activity provision, the service advised that a structured group programme would been implemented alongside increased volunteer involvement, complementary therapies and additional psychology-led groups, with participation and engagement monitored through care planning and monthly audit processes.

On the day of this visit, we wanted to follow up on the previous recommendations and the actions taken by the service. We wanted to meet with individuals, staff and relatives/carers, as well as reviewing the care and treatment being offered in the unit.

Who we met with

We met with six people and reviewed eight sets of care records. We did not meet any relatives/carers on the day of the visit however, we contacted six carers/relatives after the visit had taken place.

We spoke with the SCN, the consultant psychiatrist, nursing staff, OT, the clinical nurse manager and the general manager on the day of the visit.

Following the visit, we contacted the Mental Health Advocacy Project, who provided advocacy services to the unit.

Commission visitors

Kathleen Liddell, social work officer

Lesley Paterson, senior manager for practitioners

Susan Hynes, nursing officer

What people told us and what we found

The individuals we spoke with on the day of the visit provided mainly positive feedback about their care and treatment in REDU. All individuals told us that staff were “kind and compassionate” and one individual stated that staff “really wanted to help me recover”, which they felt was supportive in their recovery journey.

We heard that individuals met regularly with the consultant psychiatrist and had frequent input from medical staff and the wider MDT.

Individuals who had input from psychology spoke positively about this support and described the psychologist as “approachable and supportive”.

However, all individuals that we spoke with raised concerns regarding staffing in REDU. We were told that bank staff were used regularly and agency staff occasionally covered shifts in the unit. Individuals reported that many bank and agency staff did not have the same specialist knowledge and expertise in eating disorders as permanent REDU staff, which caused anxiety about the quality and consistency of care being provided. Those that we spoke with gave us examples of mealtime and post-meal support being particularly important and requiring specialist eating disorder knowledge and therapeutic support, as these were often the most distressing and challenging parts of the day.

We were concerned to hear that there were occasions when staffing pressures resulted in limited availability of staff to provide post-meal support, with individuals at times being left alone during these periods. However, it was reassuring to find out that individuals had raised these concerns in their weekly community meeting, although we were disappointed to hear from those that we spoke with that they felt there had been limited progress in resolving the staffing issues.

We heard that staffing pressures had also had impact on the availability of regular one-to-one interventions with key nurses, despite these being identified in care plan interventions, goals and outcomes. All individuals told us that they valued the one-to-one support and found this beneficial in allowing them to discuss their views, thoughts and feelings.

Most individuals we met were aware of their legal status and rights and all individuals told us they had access to advocacy services. Some individuals, particularly those receiving care and treatment informally, raised concerns regarding what they perceived to be “blanket restrictions” in the unit.

We heard that restrictions such as locked bathroom doors on admission were applied routinely and some people felt these restrictions were disproportionate to their individual circumstances and would prefer a more personalised approach to risk assessment. Some individuals reported that although they disagreed with

aspects of the restrictions in place, they did not feel comfortable challenging the MDT due to fears this could negatively impact on their care or result in discharge from the unit.

When discussing care planning, most individuals told us they were aware of their care plan and had been involved in the initial completion of it. However, most of the people that we spoke with said that they felt less involved as their admission progressed and over times, they were unclear whether changes had been made to their care plan.

We also heard from several individuals that they did not have the clarity they would have liked regarding future planning and the expectations of what needed to progress in their move towards discharge. Some individuals with previous admissions reported concerns that they had previously been discharged prematurely and without sufficient discharge planning, leading to anxiety that this may happen again.

There were mixed views regarding involvement in decisions about care and treatment. Some individuals told us they would prefer greater involvement in weekly MDT meetings and were dissatisfied with the quality and consistency of feedback provided following MDT discussions. We heard that for some, feedback varied depending on which MDT member delivered it, and that there was not always sufficient time to discuss the rationale behind decisions; this left some people feeling upset and distressed.

All individuals agreed that the monthly care plan review meetings were beneficial, although some felt that monthly meetings were not frequent enough and that there could be lengthy periods between times where there were formal discussions and reviews.

All those that we spoke with told us that they would prefer more activities to be available in REDU. We heard that a timetable of structured and unstructured groups was available, facilitated by nursing staff, OT and physiotherapy staff. Individuals told us that not everyone was assessed as able to attend groups and that there were limited alternative activities available. This resulted in prolonged periods of unstructured time. We also heard concerns that some groups did not run as scheduled, particularly nursing-led groups, due to staffing pressures in the unit.

Comments from relatives/carers

Relatives and carers provided mixed feedback regarding care and treatment in REDU. Most relatives spoke positively about the specialist eating disorder care provided by the MDT and described staff as caring, supportive and committed to the individuals' recovery.

Families valued regular communication with staff, particularly the involvement of the consultant psychiatrist and attendance at monthly review meetings, where many felt listened to and involved in discussions regarding care and treatment.

Several relatives highlighted the positive impact of psychology input and acknowledged the benefits of specialist multidisciplinary interventions.

Again, families and relatives raised with us similar concerns to the individuals in REDI in relation to staffing pressures in the unit about the reliance on bank and agency staff who had limited specialist eating disorder knowledge and experience.

They too felt this had a negative impact on the consistency and quality of care, especially during mealtimes and post-meal support, which were viewed as the most distressing and important aspects of treatment. Concerns were also raised regarding wider MDT communication, discharge planning and the level of involvement families had in ongoing decision-making.

Some relatives described discharge planning as unclear, inconsistent or insufficiently collaborative, and several felt there was a lack of clear future planning and regular review between monthly meetings. There were relatives that expressed concerns that care and treatment focused primarily on weight restoration and eating disorder symptoms, without always adequately addressing underlying mental health needs or additional diagnoses.

Most relatives welcomed the introduction of carer support groups and recognised the value of increased support for families, relatives and carers, although some advised they had not been aware of meetings taking place.

Overall, while relatives were generally positive about the commitment of staff and specialist care provided in REDU, they identified ongoing concerns regarding staffing, communication, consistency of care and collaborative discharge planning.

Care, treatment, support, and participation

We were told, and saw, that NHS Lothian had implemented a new person-centred care planning system in April 2025, following the Commission's previous visit to REDU.

The revised care planning documentation on TRAKCare included a range of headings intended to support a more holistic approach to care, including mental health, stress and distress, meaningful activity, physical health, activities of daily living, discharge planning and family/carer involvement.

During the previous three visits, the Commission has made recommendations that care plans should demonstrate greater participation from individuals. We were pleased to find some improvement in this area.

Several care plans evidenced the involvement and views of the individual, which reflected the feedback provided by individuals during the visit.

We reviewed eight care plans and found them to be of mixed quality. Some care plans contained comprehensive and personalised information, while others lacked detail and consistency.

We found examples where only some sections of the care plan had been completed despite additional headings that were relevant to the individual's assessed needs. For example, some individuals who were detained did not have a legislation care plan completed.

We discussed this with the senior management team and asked about the auditing arrangements referenced in the service action plan following the previous Commission visit. We were advised that, due to the implementation of the new care planning system, development of the auditing process through the medical E-governance (MEG) system was ongoing and expected to be implemented imminently. We will review care planning arrangements during future visits to assess whether implementation of the auditing system has supported improved consistency and quality in care planning documentation.

We were pleased to see some positive examples of person-centred care planning, particularly where the 'what matters to me' and 'distress preferences' sections had been completed. These sections provided more personalised information and supported a more individualised approach to care and treatment. However, these sections were not consistently completed across all care plans reviewed, resulting in variable evidence of person-centred care.

Although the revised care planning format provided greater opportunity for collaborative and holistic care planning, we found that much of the information recorded remained focused on identified problems, with less emphasis on recovery goals, strengths, outcomes and a solution-focused approach to care and treatment.

At times, we were unable to identify clear and measurable care, treatment and recovery goals, or sufficient detail regarding how individuals and the MDT would work together to support progress towards these outcomes. Interventions recorded in care plans often lacked comprehensive detail regarding the support required, how interventions would be implemented and which members of the MDT were responsible for providing this support. This made it difficult to ascertain how at times, care plan outcomes would be achieved and reviewed in practice.

We were pleased to find evidence of wider MDT involvement in care planning documentation, which supported a more holistic approach to individuals' care, treatment and support.

We initially found it difficult to locate clear information relating to discharge planning, as none of the care plans that we reviewed had the discharge planning section completed.

We raised this with the service and were advised that discharge planning was generally discussed during monthly care plan review meetings; records of these meetings were not routinely stored on TRAKCare. We were able to review records of some monthly care plan meetings, which demonstrated comprehensive MDT discussion regarding individuals' care and treatment.

We discussed with the service that we would expect discharge planning goals, interventions and outcomes to be clearly recorded in the care plan itself to ensure there was a clear and accessible record of future planning and progression towards discharge.

We were able to see that care plan reviews were taking place, however the information recorded was often brief and mainly stated whether the care plan remained relevant or not. There was limited evaluative information regarding each individual's progress, the effectiveness of interventions, which aspects of the care plan remained supportive, or whether changes to care and treatment were required.

We were also unable to clearly identify the outcomes of decisions made during monthly review meetings or how these discussions informed and aligned with ongoing care planning documentation. Although we were able to see evidence of comprehensive MDT discussion during monthly review meetings, this was not consistently reflected in the care plans themselves. As a result, there was limited continuity between review discussions, agreed actions, updated interventions and recorded care plan outcomes.

We raised similar concerns during the previous visit and were disappointed to find limited improvement in the quality and depth of care plan review documentation. We discussed with the senior management team that the review template currently used by NHS Lothian did not readily support the recording of comprehensive, evaluative information that informed meaningful care plan review, progression and discharge planning.

The Commission has published a good practice guide on care plans[1]. 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.

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

Recommendation 1:
Managers should ensure that care plan reviews include comprehensive evaluative information regarding the individual's progress, the effectiveness of interventions, ongoing care and treatment needs, and any required changes to care planning. Care plan review documentation should support meaningful, recovery-focused evaluation and clearly evidence how care and treatment is progressing towards agreed outcomes.

When we reviewed the risk assessments, we found them to be of mixed quality. In the previous visit report, we noted that risk assessments varied in quality, lacked sufficient detail regarding current risks, and did not consistently provide clear rationale for restrictions in place. We found that there was little improvement in this area during this visit.

In some cases, particularly where individuals had complex physical health needs, the risk management plans were comprehensive and clearly set out the interventions required, with appropriate detail regarding ongoing monitoring and management.

In other cases, particularly for individuals with complex mental health needs, risk assessments contained a substantial amount of historical information, which made it difficult to ascertain what was the current level of risk and ongoing need. In these instances, risk management plans were not sufficiently robust or detailed, and did not consistently provide clear guidance regarding current risks, required interventions, how risks should be managed in practice, or the rationale for restrictions in place.

Recommendation 2:
Managers should ensure that risk assessments and risk management plans are current, individualised, and clearly identify present risks, protective factors, required interventions, and the rationale for any restrictions in place. Risk assessments should support a recovery-focused and least restrictive approach to care, be regularly reviewed, and clearly reflect changes in the individual's presentation and level of risk.

Care records
Information relating to individuals' care and treatment continued was held electronically on TRAKCare, which we found easy to navigate.

The quality of documentation reviewed was generally good, with the majority of information being detailed, strengths-based and focused on individuals' presentation, care and treatment needs. However, we found some examples of language in care records that was not reflective of a rights-based or person-centred approach, including phrases such as "pushing boundaries", "demanding", and "patients are required too". We discussed with the SCN the importance of ensuring

that language used in clinical documentation remains respectful, recovery-focused and reflective of individuals' rights and experiences.

We were pleased to see that all members of the MDT contributed to the care records. We found good examples of comprehensive documentation from psychology, dietetic staff, OT and physiotherapy, where the purpose of interventions, therapeutic input and outcomes were clearly recorded.

We also found physical healthcare documentation to be of a high standard. There was evidence that individuals with complex physical healthcare needs had been appropriately referred to specialist services for assessment and review; we could see that all potential treatment options were being actively considered and monitored.

We also saw regular review and oversight from the consultant psychiatrist and specialty doctor, with comprehensive documentation of mental health assessment and treatment planning.

There was limited evidence of regular one-to-one interventions between nursing staff and individuals, despite these being identified in care plan goals and outcomes. Where one-to-one interventions had taken place, the quality of recording was good and demonstrated supportive and compassionate interactions, with clear discussion regarding the individual's feelings, views and any worries they had. These interactions reflected the therapeutic value of one-to-one support and the benefit individuals placed on having time to speak openly with staff.

We were pleased to find that the care records included regular communication with families, relatives and other professionals. In particular, there was evidence that the consultant psychiatrist made regular contact with family members to discuss care and treatment options and the views of families were clearly recorded in the records.

Multidisciplinary team (MDT)

REDU continued to have a broad range of disciplines either based in the unit or accessible to the service. The MDT included nursing staff, consultant psychiatry input, speciality doctors, psychology, dietetics, OT and physiotherapy.

The MDT met weekly in the unit. We found detailed recording of MDT discussion and decisions on the structured ward round template. Most members of the MDT either attended the meeting or contributed information in advance, which supported a collaborative and holistic MDT approach to individuals' care, treatment and support in REDU.

Following the Commission's previous visit, we were told that the service had reviewed how individuals participated in the weekly MDT meeting and had trialled different approaches, including individuals attending the meeting in person. We were

advised that the agreed process remained that individuals completed a written request form prior to the MDT meeting, with requests discussed by the MDT and feedback subsequently provided to the individual by a member of the team following the meeting.

We were able to see the requests made by individuals clearly recorded in the MDT documentation however, the rationale for decisions reached by the MDT was inconsistently recorded. We also found variability in the quality of documentation relating to feedback discussions with individuals following the MDT meeting. Some records contained comprehensive information regarding the discussion, including the individual's views, responses and any follow-up agreed, whereas other entries recorded only brief information.

This reflected the feedback provided by some individuals during our visit, where we heard that individuals did not always feel fully involved in decision-making or provided with a sufficient explanation regarding decisions made about their care and treatment. It was understandable why some individuals remained dissatisfied with the current arrangements and we discussed this with the senior management team.

In addition to the weekly MDT meetings, we saw evidence that monthly progress review meetings continued to take place. These meetings involved the MDT, individuals, family members/carers where appropriate and community services.

We were pleased to see evidence of family involvement in the review meetings and of discussions regarding ongoing care, treatment and future planning.

Use of mental health and incapacity legislation

On the day of the visit, six 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, including certificates around capacity to consent to treatment, was electronically stored on TRAKCare and easily located.

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.

On cross-checking the electronic records, we found that the responsible medical officer (RMO) had completed either a T2, T3 or T4 certificate for four individuals in REDU. On review of the documentation, we found that all four individuals had medication prescribed which was not authorised under the corresponding T2 or T3 certificates.

We highlighted this issue on the day of the visit and were assured by the consultant psychiatrist that an urgent review of the consent to treatment documentation would be undertaken. We were also advised that individuals would be informed of the unauthorised treatment and their rights in relation to this.

We discussed with the senior management team that there appeared to have been a deterioration in the quality and oversight of consent to treatment documentation since the previous visit. We were told that regular pharmacy input and auditing had previously supported monitoring of the T2 and T3 certificates however, this input was no longer routinely available due to staffing pressures in the pharmacy service.

We were advised that the service would discuss with pharmacy colleagues reinstating pharmacy support. We also discussed the importance of the service implementing local audit processes to improve oversight and governance in this area.

Recommendation 3:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, that all psychotropic medication is legally authorised and that an audit system is put in place to monitor this.

Anyone who receives treatment under the Mental Health Act can choose someone to protect their interests; that person is called a named person. Where a named person had been nominated, we found this stored on TRAKCare.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (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.

We reviewed one section 47 certificate which had expired on the day of the visit. When we asked staff whether there remained a requirement for the certificate to be in place, we were concerned that some staff were unaware that the form existed and appeared to have a limited understanding of the purpose and remit of a section 47 certificate, referring to it as “an AWI”.

We discussed with the senior management team the importance of staff having a clear understanding of the relevant legal frameworks in place for individuals in REDU, and that they needed to ensure that all current legal documentation was clearly recorded and easily accessible on TRAKCare for staff reference. We also highlighted the importance of robust governance arrangements to ensure legal documentation is reviewed regularly and remains current and valid.

We advised the service that the Commission and NHS Education for Scotland (NES) had jointly developed national training in relation to Part 5 of the AWI Act, which supports staff understanding of capacity assessment, treatment authorisation and the upholding of individuals' rights. The training can be accessed here: New TURAS Learn Zone – Adults with Incapacity | NHS Education for Scotland

Recommendation 4:
Managers must ensure that all section 47 certificates are appropriately completed, current, regularly reviewed, and clearly accessible within the electronic record system. Staff should have a clear understanding of the Adults with Incapacity (Scotland) Act 2000, including the purpose and application of section 47 certificates, to ensure treatment is lawfully authorised and individuals' rights are upheld.

We also reviewed one 'do not attempt cardiopulmonary resuscitation' (DNACPR) certificate that had originally been completed in a previous ward setting. The Commission identified the DNACPR documentation on TRAKCare. Staff that we spoke with on the day of the visit were unaware that a DNACPR decision was in place for the individual. When we reviewed the form, we found that it had not been completed fully or appropriately. Although there was agreement among staff that the DNACPR decision remained clinically appropriate, there was uncertainty regarding whether the original documentation remained valid and appropriately authorised.

We provided advice to the service on this matter and discussed the importance of staff understanding the relevant legal frameworks, ensuring that legal documentation was appropriately completed, current, and readily accessible on the electronic record system.

It is fundamental that all healthcare staff involved in an individual's care are aware that a DNACPR decision has been made and appropriately documented. This is essential to ensure that CPR is not inappropriately withheld where indicated, and equally to prevent inappropriate, non-beneficial or unwanted attempts at CPR that may cause significant distress to individuals and their families.

Recommendation 5:
Managers should ensure that all DNACPR decisions are reviewed and there is a consistent system to ensure that all staff members are aware of the DNACPR status of every individual on the ward.

Rights and restrictions

REDU continued to operate a locked door policy. The Commission has raised concerns in the previous three local visit reports regarding aspects of restrictive practice, and we were encouraged to be told that the service had been working on and implementing approaches and strategies to support more rights-based care.

We heard that, prior to admission, individuals were provided with information about the unit, including a video outlining expectations and restrictions, and that a pre-admission pack would be available imminently. We also heard that, for some individuals, a pre-visit meeting was arranged to provide an opportunity to meet staff and ask questions about admission.

Individuals we spoke with acknowledged that they had been provided with information prior to admission however, they also reported that it was difficult to fully process this information at the point of admission due to high levels of stress and distress. They indicated that ongoing discussion and reinforcement of information regarding their rights and any restrictions in place would be beneficial.

In the previous report, we raised concerns that the admission criteria and consent form used in REDU was not sufficiently person-centred, that it placed excessive and standardised restrictions on all individuals, including those admitted informally, and did not consistently demonstrate evidence of fully informed consent. We were pleased to hear that the service had reviewed this practice and had taken the decision to discontinue the previous consent form.

We saw further progress in promoting rights-based care, with improved access to information on rights across the ward environment, including wall displays and QR codes. Most individuals we spoke with were aware of their legal status, their rights, and had access to advocacy and/or legal representation. This indicated an improved level of awareness of rights in the unit compared to previous visits, although this awareness was not always consistently reflected in practice.

Despite these improvements, we continued to have concerns regarding the use of restrictions for individuals admitted on an informal basis. We found that some restrictions, particularly those in place at the time of admission, such as locked bathroom doors and limits on unaccompanied time off the ward, continued to reflect a standardised approach rather than being fully individualised.

We were unable to identify clear and consistent MDT rationale for the application and ongoing continuation of these restrictions. In some cases, it was not clear how restrictions linked to individual risk assessment findings or care plan outcomes.

We also found that documentation did not consistently evidence fully informed consent or clear reference to the legal framework underpinning the restriction.

We discussed with the service that the Commission would expect all restrictive practices to be clearly and consistently recorded in care plans, with explicit rationale linked to assessed risk, alongside measurable goals, interventions, and defined criteria for review and reduction. This would support a clearer, rights-based and least restrictive approach to care, consistent with the principles of the European Convention on Human Rights, in particular Article 5 (right to liberty and security) and

Article 8 (right to respect for private and family life), ensuring that any interference with rights is lawful, necessary, and proportionate.

We also discussed that where significant restrictions are required for individuals receiving care on an informal basis, the MDT, including a mental health officer (MHO), should consider whether the use of the Mental Health Act may be more appropriate. This would ensure that any restrictive measures are supported by an appropriate legal framework, with access to the safeguards, rights, review processes and protections available under the legislation.

We saw that restraint was being used for some individuals. We reviewed the relevant care records and found that, where restraint had been required, incidents were recorded through DATIX reporting. We found that there was no clear corresponding care planning documentation outlining the rationale for the use of restraint, de-escalation strategies utilised, or the psychological and therapeutic interventions provided during or following incidents.

Similarly, where continuous intervention (CI) was in place for some individuals, we were unable to locate a specific care plan setting out the purpose, level of intervention required, or review arrangements. This issue had previously been highlighted by the Commission, and we had made a recommendation that enhanced observation should be clearly recorded, regularly reviewed, and underpinned by appropriate policy. Despite this, we found limited evidence of improvement in this area during this visit.

A weekly community meeting continued to take place in the unit. Most individuals we spoke with told us they found this meeting to be supportive and useful, and valued the opportunity to raise issues affecting the ward environment and their care. We heard that individuals had used this forum to raise important issues, including the use of bank staff and the impact this had on consistency of care and support, enabling constructive discussion between individuals and staff regarding its impact on their experience within the unit.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 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 found one advance statement on file. While this may provide evidence of anticipatory care planning, this remains limited and further work is required to ensure consistent promotion and use of advance statements across all individuals in the service.

Advocacy was provided in the unit by the Mental Health Advocacy Project (MHAP), who provided collective advocacy every six weeks alongside individual advocacy

support. We saw and heard that many individuals in the unit had regular contact with advocacy services.

We contacted MHAP following the visit and asked whether there were any themes raised by individuals regarding rights, care and treatment in the unit. We were told that there were regular referrals from REDU, mainly following detention under the Mental Health Act, often initiated by the MHO. We also heard that REDU staff were supportive of the collective advocacy sessions and encouraged individuals to attend.

Themes raised through collective advocacy included concerns regarding staffing levels, the use of bank staff who did not always have specialist eating disorder knowledge and experience, particularly in relation to support during mealtimes, and the use of locked bathroom doors on admission. We were told that some individuals viewed these restrictions as unnecessary and overly restrictive in relation to their individual circumstances.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Overall, we were encouraged to see that the service was progressing how to strengthen the awareness of rights and improve access to rights-based information although further work is required to ensure that rights are consistently embedded in practice. In particular, restrictions, enhanced observation, and restrictive interventions must be individualised, clearly justified, proportionate, and regularly reviewed in line with a rights-based and least restrictive approach, so are repeating this recommendation.

Recommendation 6:
Managers must ensure that rights-based care is consistently embedded in practice across REDU. Restrictions, enhanced observations and restrictive interventions should be individualised, proportionate, linked to assessed risk and care plan outcomes, and regularly reviewed in line with a least restrictive approach. Care records should clearly evidence rationale, legal authority, where applicable, and discussions regarding informed consent.

Activity and occupation

We made a recommendation in the previous report that structured activities with a therapeutic and well-being focus should be regularly available to individuals in REDU. During this visit, we found that some progress had been made in this area. We saw that the ward had an activity timetable in place, offering a range of both structured and unstructured activities. We were advised that new admissions may initially

[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

access unstructured activities before progressing to structured groups as part of their treatment journey.

We saw a range of structured therapeutic, psychoeducational and self-care groups were available, including life skills sessions (such as budgeting, applying for jobs and credit card management), exercise management, self-care and relaxation groups, decider skills, and body image/health-focused work. We were also pleased to hear that all staff were being trained in Decider skills training and that this was planned as a daily morning activity; however, we were told that this did not always run due to staffing pressures.

Even with these improvements, we heard from individuals that if they were unable to attend structured groups, that there was limited alternative activity available, which resulted in periods of boredom and unstructured time. We also heard from younger individuals that some of the unstructured activities, such as arts and crafts and jigsaws, were not always of interest to them and that a more personalised approach to activity provision would better meet their needs and support recovery.

We were pleased to hear of the increased involvement from volunteers in the unit, providing activities such as therapet sessions and complementary therapies. We were also advised that a sound bath session held over the Christmas period received very positive feedback from individuals, and as a result the service had funded additional sessions.

We were informed by the OT that the activity programme was reviewed regularly to support ongoing development and responsiveness to individuals' needs.

The physical environment

REDU's environment was bright and spacious. There is a hub area in the centre of the unit which was well used by individuals and staff. The unit also has a family room where individuals can spend time with relatives and carers. The family room is child-friendly and includes toys and resources for visiting children.

Communal areas, including the dining room and lounge, are spacious and provide opportunities for social interaction and activity. The lounge also offers a range of activities such as board games and arts and crafts for individuals to engage in, and soft furnishings are in place which support a more homely and comfortable environment.

There is a laundry room and kitchen that is available for individuals to use to complete their own laundry and to participate in meal preparation. Where appropriate, this was included in care plans. The cleanliness of the unit was of a good standard, and the décor was well maintained.

We noted a positive development since the previous visit, with increased artwork displayed throughout the unit, including pieces created by individuals, alongside positive affirmations from both current and former individuals in the unit. This contributed to a more therapeutic and welcoming environment for individuals in the service.

We were able to view some individual bedrooms and we observed that some people had chosen to personalise their rooms, which supported a more homely and individualised living environment. All bedrooms have en-suite facilities, and personalisation of rooms was actively encouraged.

Individuals also have access to a spacious garden area with seating.

We were informed that a new alarm system had recently been installed in the unit, which will provide a pin-point alarm system. At the time of the visit, this system had not yet been activated, and individuals continued to use the current buzzer system until the new system is fully operational.

Any other comments

We found that REDU continued to demonstrate some progress since the previous visit, particularly in relation to improved visibility of rights-based information, continued MDT working, and some strengthening of care planning following the introduction of the revised person-centred template.

Individuals and relatives generally spoke positively about staff and valued the specialist MDT input, psychology support, and opportunities for involvement in review meetings.

We do however continue to identify areas requiring improvement, a number of which we have made previous recommendations on. Care plans and risk assessments remained inconsistent, with limited evidence of clear links between assessed need, outcomes and interventions, and variable use of a recovery-focused approach.

Restrictive practices for people admitted informally were not always clearly individualised or supported by documented MDT rationale, and recording of informed consent and enhanced observation remained inconsistent.

Relatives also raised concerns regarding communication, staffing consistency, discharge planning and access to meaningful activity.

Overall, further work is required to ensure care and treatment in REDU is consistently person-centred, rights-based and clearly reflected in both documentation and practice.

Summary of recommendations

Recommendation 1:
Managers should ensure that care plan reviews include comprehensive evaluative information regarding the individual's progress, the effectiveness of interventions, ongoing care and treatment needs, and any required changes to care planning. Care plan review documentation should support meaningful, recovery-focused evaluation and clearly evidence how care and treatment is progressing towards agreed outcomes.

Recommendation 2:
Managers should ensure that risk assessments and risk management plans are current, individualised, and clearly identify present risks, protective factors, required interventions, and the rationale for any restrictions in place. Risk assessments should support a recovery-focused and least restrictive approach to care, be regularly reviewed, and clearly reflect changes in the individual's presentation and level of risk.

Recommendation 3:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, that all psychotropic medication is legally authorised and that an audit system is put in place to monitor this.

Recommendation 4:
Managers must ensure that all section 47 certificates are appropriately completed, current, regularly reviewed, and clearly accessible within the electronic record system. Staff should have a clear understanding of the Adults with Incapacity (Scotland) Act 2000, including the purpose and application of section 47 certificates, to ensure treatment is lawfully authorised and individuals' rights are upheld.

Recommendation 5:
Managers should ensure that all DNACPR decisions are reviewed and there is a consistent system to ensure that all staff members are aware of the DNACPR status of every individual on the ward.

Recommendation 6:
Managers must ensure that rights-based care is consistently embedded in practice across REDU. Restrictions, enhanced observations and restrictive interventions should be individualised, proportionate, linked to assessed risk and care plan outcomes, and regularly reviewed in line with a least restrictive approach. Care records should clearly evidence rationale, legal authority, where applicable, and discussions regarding informed consent.

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 an individual's care, treatment, and support are 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