Mental Welfare Commission for Scotland

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

Date of visit: 20 December 2016

Where we visited

We visited the Eden Unit, Royal Cornhill Hospital. The Eden Unit is a specialist eating disorders service based within the Clerkseat building at Royal Cornhill Hospital. It accepts referrals from Tayside, Grampian, Highlands, Orkney, Shetland and the Western Isles. There are 10 beds available for in-patients; three to four places for day care; and accommodation for both female and male patients.

The unit is staffed by a multidisciplinary team from various professional backgrounds. On the day of our visit there were 10 inpatient beds occupied and all but two patients were subject to compulsory measures. We last visited this service 23 January 2014 and made the following recommendation: a robust system should be put in place to ensure that Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) consent to treatment certificates (T2/T3) are completed when required.

On the day of this visit we wanted to follow up on this recommendation.

Who we met with

We met with and/or reviewed the care and treatment of six patients.

We spoke with the unit manager, staff nurses and other clinical staff.

Commission visitors

Douglas Seath, Nursing Officer

Margaret Christie, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

The unit was full at the time of our visit, with one patient currently boarded out to another hospital. The patient files we reviewed all contained individual safety plans and this linked to their mental health recovery plans, planning towards discharge from hospital. Several patients were from out of area but were linked in with the referring service for discharge arrangements. Follow up in other areas, however, did not always match what can be provided for Grampian patients, and this could be problematic in terms of forward planning.

There were care plans in place to manage all aspects of care, though these were somewhat lacking in personalisation. We found the nursing entries were generally of a good standard, especially where therapeutic one to one time was recorded. However, the care plans we reviewed varied in quality and often lacked individualised content.

Although issues were identified and goals were outlined, the detail of how the goals should be achieved was not always present. On speaking with nursing staff, this information was often known, but the details were not recorded in writing. We believe this is an important area for improvement.

There was evidence of patient involvement in reviews and in compilation of care plans. We heard that patients can submit their comments and views for the weekly ward round, and receive feedback from a member of staff after the meeting. We were told by staff that patients are also invited to attend a formal regular review.

The family based therapy offered to all patients allowed for close working relationships with others involved in their care and support. Although care plans were being reviewed, the reviews lacked detail in regard to interventions and progress around the goals set. We heard from patients that they are satisfied with the ward round process.

The unit is staffed with support from medical, nursing, occupational therapy, psychology staff and there is input from speech and language and dietetic professions. The service is thus able to offer family based therapy, cognitive behavioural therapy and inter personal therapy in addition to activity and recreational groups.

Recommendation 1:

The charge nurse should regularly audit care plans to ensure the content is person-centred and is regularly reviewed and updated for each patient.

Use of mental health and incapacity legislation

There were problems with the documentation regarding medical treatment for two compulsorily detained patients. For one patient, a T3 form existed but was difficult to find in case notes. Another patient had no T2 or T3 form despite the need for one of these forms. Problems with this documentation were brought to the attention of the ward manager so that they could be remedied as quickly as possible.

Recommendation 2:

A system should be implemented and audited to ensure that the correct paperwork (e.g. T2 or T3 form) is in place and accessible for patients subject to compulsory treatment. As this matter was raised on the previous visit, we will now bring this to the attention of the medical director for eating disorders.

Rights and restrictions

Patients are regularly subject to enhanced observations as part of their recovery plan and require staff to be present at particular times during the day. Staff adhered to national guidelines on use of observation and are able to use some discretion where patients have single rooms.

Enhanced observation is often a source of irritation and frustration for patients but we found evidence that privacy and dignity is respected as far as possible within the requirements of the nurses' duties.

Some compulsorily detained patients had restrictions placed on their use of phones, access to the internet and need for searching. Although this was clearly documented and authorised by Mental Health Act RES (specified persons) forms, reasoned opinions were hard to locate and it was not always clear from the record whether the restrictions were active or had been discontinued.

Recommendation 3:

Managers should keep an index of Mental Health Act documentation with dates indicating when reviews are due and introduce regular audit of these.

Recommendation 4:

Managers should ensure that reasoned opinions are co-located with RES (specified person) forms.

Activity and occupation

There is a daily activity programme displayed prominently in a central location on the ward. There was evidence of patients being invited to attend activities. However, much of the nurses' time is taken up with the individual patient programmes with clear therapeutic benefit of one to one input given priority.

The physical environment

The ward was generally clean, bright and in good condition. There was a generous amount of space for activities and group work. A garden area was available for patients. There were no issues identified with the environment of the ward.

Summary of recommendations

1. The charge nurse should regularly audit care plans to ensure the content is person-centred and is regularly reviewed and updated for each patient.

2. A system should be implemented and audited to ensure that the correct paperwork (e.g. T2 or T3 form) is in place and accessible for patients subject to compulsory treatment. As this matter was raised on the previous visit, we will now bring this to the attention of the senior manager for eating disorders.

3. Managers should keep an index of mental health act documentation with dates indicating when reviews are due and introduce regular audit of these.

4. Managers should ensure that reasoned opinions are co-located with RES (specified persons) forms.

Service response to recommendations

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

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

Douglas Seath

24 January 2017

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 MWC 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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