



**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:** 3 October 2017

## **Where we visited**

The Regional Eating Disorders unit (REDU), based at St John's Hospital, offers specialist in-patient care for up to 12 patients from NHS Lothian, NHS Fife, NHS Forth Valley and NHS Borders.

The multi-disciplinary team (MDT) consists of psychiatry/psychotherapy, nursing, psychology, occupational therapy (OT) and dietetics that provide input into the care of the patients.

This was an announced visit. Our last visit to the service was on 11 September 2015 and at that time we made recommendations in relation to auditing the nursing care plans, addressing the lack of OT, psychology and pharmacy and for consent forms (T2/3s) to be filed in the medicine kardex. We received a satisfactory response to these recommendations in November 2015.

On this occasion, we visited to review the care provided for some of the 11 patients who are currently in-patients. We were able to ask about their care and treatment. We were able to speak with relatives, as well as talking to members of the MDT. We were interested to review the following areas specifically:

- Care planning
- Use of legislation
- Person centred care
- Activities.

## **Who we met with**

There were two patients who agreed to meet with us on the day. There were no carers that wished to speak with us at that time, however we have since been in contact with one of the carers. We reviewed six sets of notes.

We also met with the senior charge nurse (SCN) the clinical nurse manager (CNM), the consultant psychiatrist/consultant psychotherapist and the occupational therapist.

## **Commission visitors**

Claire Lamza, Nursing Officer (visit coordinator)

Dr Juliet Brock, Medical Officer

## **What people told us and what we found?**

### **Care, treatment, support and participation**

We recognise that providing care for this group of patients can be challenging, given the significant health issues that are associated with an eating disorder combined with the symptoms and behaviours connected to the individual's mental health.

There are currently several patients who require intensive levels of observation due to the risk of serious self-harm and this has needed to be the focus of treatment. There are also some patients who are being considered for out-of-area specialist care due to the complexity of their diagnoses.

We found that the care plans reflected the complexity; they were detailed, clearly set out in terms of care goals and with weekly reviews. There is also a pre-review template that provides an opportunity for patients to identify and participate in their care needs. When completed, these gave information about the views of the patient, although this was not always the case.

**Recommendation 1:** The senior charge nurse should ensure staff support patients completion of views and opinions on pre-review form and note rationale for non-completion.

We are also pleased to note that since our last visit, psychology, occupational therapy, pharmacy and psychotherapy services have all improved, with these clinicians now in post and routinely contributing to the care and treatment delivered in REDU.

### **Use of mental health and incapacity legislation**

For the patients we met with and reviewed, all were cared for under the Mental Health (Care & Treatment) (Scotland) Act 2003. We found the documentation for those who were detained under the Mental Health Act up-to-date and filed in their care plans. There is a useful form, Mental Health Act (2003) (Scotland), which provides dates in relation to detention, but also other helpful information such as advance statements and named persons. We were pleased to see that in one of the notes we reviewed there was an advance statement, but this was not held in the care plan.

**Recommendation 2:** The senior charge nurse should encourage promotion of the use of advance statements where possible and for existing statements to be held in care plan.

We also noted that, where required, there were T2, T3 and T4 forms, all of which were in the patients care plans.

### **Rights and Restrictions**

On the day of our visit, there were some patients who were being cared for in their rooms and on intensive observation. On speaking to one of them, they described feeling “trapped in their room” and would have preferred to have opportunities to talk about their care outwith their sleeping environment.

In addition to this, and following on from a discussion with a carer, we were advised that when this level of observation is taking place, there can be a lack of structured, meaningful activity that would offer a distraction or support psychological improvement for the individual. We find this to be restrictive and believe the service needs to develop a more positive approach to the management of risks.

We acknowledge that the type and level of structured contact will vary according to patient need, as well as symptoms and behaviours associated with different diagnoses, however a more individualised approach needs to be offered when patients are under increased observation levels.

**Recommendation 3:** The service manager should lead on developing a local protocol that promotes and provides for individualised, structured, one-to-one contact where the risks are managed in a person-centred way during periods of constant or intense observation.

We were made aware that a recent situation had resulted in several patients requiring to be made specified persons. On the visit, we had an opportunity to fully discuss the rationale for the actions taken by the clinical team. We were informed that all patients were given information about the need for the service's response, about their right of appeal, access to advocacy and the review process.

We note that there was a letter confirming this in the care plans, although the letters were not dated and did not provide a written explanation reiterating the patients' rights. There was also no written record of the right to appeal. The Commission has developed 'Rights in Mind' guidance and would encourage the service to consider taking this forward.

**Recommendation 4:** The senior charge nurse should ensure patients have information on the right of appeal regarding specified person and revoke the restrictions as soon as the risk is managed. Staff should refer to the Commission's 'Rights in Mind' guidance to promote awareness across the unit.

We noted that there is access to advocacy and legal representation, and where the individual wished this, those services were actively involved.

## **Physical Environment**

We found the environment to be pleasantly decorated and well maintained. There is a quietness about the unit, partly because of its spaciousness but also because the individual areas- bedrooms, dining area, interview/group rooms – are separate rooms. There is a garden area, which is accessible on request, with a sign indicating this. The environment is free from smoke.

## **Activity and occupation**

There are a range of activities on offer for patients and a record of what is available (and attended) is kept in the care plan. We were also pleased to find that with the appointment of the OT, there have been more rehabilitation activities taking place outwith the unit.

Activities we found noted in care plans included individual psychotherapy sessions and/or "floating appointments", mindfulness, anxiety management, body awareness,

relaxation and welfare benefits advisor appointments. Each individual had their own programme, and the day-to-day/weekly structured routine for the unit was displayed on the wall.

### **Any other comments**

When we met with the CNM, SCN, and the consultant psychiatrist/psychotherapist we discussed some of the recent changes in terms of the management structure. REDU has moved under the Royal Edinburgh and Associated Services (REAS) directorate, and while this change will require a period of REAS learning about the role and remit of REDU, it is hoped that in future months this will lead to development in terms of admission criteria, staffing levels and shift patterns.

### **Summary of recommendations**

1. The senior charge nurse should ensure staff support patient's completion of views and opinions on pre-review form and note rationale for non-completion.
2. The senior charge nurse should encourage promotion of the use of advance statements where possible and for existing statements to be held in care plan.
3. The service manager should lead on developing a local protocol that promotes and provides for structured one-to-one contact where the risks are managed in a person centred way during periods of constant or intense observation.
4. The senior charge nurse should ensure patients have information on the right of appeal regarding specified person and revoke the restrictions as soon as the risk is managed. Staff should refer to the Commission's 'Rights in Mind' guidance to promote awareness across the unit

### **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.

Alison Thomson  
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 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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