



**Mental Welfare Commission for Scotland**

**Report on unannounced visit to:** Eden Ward, Royal Cornhill Hospital, 25 Cornhill Road, Aberdeen AB25 2ZH

**Date of visit:** 16 January 2018

## **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 inpatients; three to four places for day care; and accommodation for both female and male patients. In addition to the inpatient ward, there are a small number of places for day care patients, often as a step down from the ward.

The unit is staffed by a multidisciplinary team (MDT) 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 on 20 December 2016 and made the following recommendations; care plans should be more person-centred; consent to treatment certificates (T2) should be subject to audit; there should be an index of all Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) documentation; all specified persons should have accessible reasoned opinions.

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

## **Who we met with**

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

We spoke with the consultant psychiatrist, the charge nurse and other nursing staff.

## **Commission visitors**

Douglas Seath, Nursing Officer

Stephen Anderson, Commission Consultant Psychiatrist

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

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

Patients in the Eden Unit have many significant health issues that are associated with an eating disorder, combined with the symptoms and behaviours connected to the individual's mental health. Several also have a dual diagnosis, and co-morbid borderline personality disorder was not uncommon amongst the patients we reviewed.

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

We found that the recovery plans reflected the level of complexity and followed on from initial risk assessments. This was an improvement on the observations of the last visit. Most were detailed, clearly set out in terms of care goals and with regular reviews. There was access for patients to psychological therapies, physiotherapy, dietetics, family therapy and occupational therapy available to all. Nursing staff were particularly singled out as being supportive and making time to speak to patients. One patient remarked that it was not necessary to seek nurses out to talk to as the named nurse would always come to see them without prompting.

For weekly review meetings, patients' views are sought prior to the meeting and feedback is provided afterwards. Patients attend the regular discharge planning reviews and carers/relatives are also invited. Patients often remain in the ward until their body mass index (BMI) is above 20 based on the assumption that this gives the individual a better chance of preventing early relapse.

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

Of the patients that we met with and reviewed, many were cared for under the MHA. We did not always find the documentation for those who were detained under the MHA easy to locate in files.

One patient complained that due to her exceeding the maximum number of days in the previous 12 months on suspension of detention, she was unable to go on a home visit over the winter holiday period. In normal circumstances, as the 200 day maximum is approached, the community treatment order should be revoked or varied to a community order. In this case, it was left too late to refer the matter to the Mental Health Tribunal and the patient was left restricted to the ward.

We reminded staff of the form, in use in other parts of the hospital, which provides dates in relation to detention, but also includes other helpful information such as advance statements, specified person and named persons. Placing this as an index at the section of the record titled 'legislation' provides an aide memoire of important review dates so that these are not missed.

There was an anomaly found in a prescription which also gave us cause for concern. A patient, admitted on a voluntary basis, was prescribed medication by intramuscular injection 'if required' for agitation. This would be inappropriate and staff agreed to have this removed from the prescription.

Another patient was prescribed a regular medication to be given by intramuscular injection if it is refused orally. This was authorised on the T2 certificate. However, it had been recorded in the 'as required' section of the medicine prescription sheet as, due to the delay, it had not always been administered at documented normal prescription time. However, as a 'regular' medication, in order to avoid confusion, it should be recorded in the appropriate section for regular medications. We also discussed whether a depot injection would be less restrictive than giving an

intramuscular injection several times per day. We were informed that this was under consideration.

**Recommendation 1:**

Managers should ensure that the index of MHA documentation is put in place with dates indicating when reviews are due and introduce regular audit of these.

**Recommendation 2:**

Managers should introduce regular audit of T2 certificates to ensure the forms legally authorise all the treatments prescribed and that entries are correctly documented.

**Rights and restrictions**

There were no compulsorily detained patients subject to specified persons' provisions of the MHA. However, some patients reported issues with access to mobile phones, tablets and Skype. There is a new policy in place where these are only permitted to be used under supervision, but the rule is not the same for everyone. This was discussed with unit manager and the new policy only applies to new admissions. The unit is engaged in a study of social media use at present and the aim is for the policy to apply to everyone equally.

**Recommendation 3:**

Managers should ensure that any policy regarding restriction of access to telephones which applies to all patients should apply to everyone equally.

Otherwise, for detained patients, use of MHA specified persons provisions allows for a more individualised approach with inherent right of appeal.

**Activity and occupation**

There is a full programme of activities displayed on the wall describing available group work in addition to individually agreed therapeutic sessions. However, some patients felt that they were prohibited from attending if their admission had occurred part way through a programme which had already commenced. Others who had been there for some time felt the groups could become a bit repetitive, especially the information and educational sessions.

Those patients described a great deal of 'down time' with little recreational activities to supplement the groups. Some felt that the unit was understaffed and that this could lead to delays and cancellations of small but important events such as walks in the grounds.

Some patients reported that they felt staff time was taken up by patients with significant self-harm issues. Consequently, it can feel at times that unless someone is visibly distressed, they may receive less support. They would like it acknowledged that they

are distressed and in need of staff support too but do not always show this in the same ways.

#### **Recommendation 4:**

Managers should ensure that staffing of the ward is sufficient to accommodate the needs of all patients and not focus on those with greater clinical demands.

#### **The physical environment**

The ward environment was described in detail in the previous report and remains clean and in a good state of repair.

#### **Summary of recommendations**

1. Managers should ensure that the index of mental health act documentation is put in place with dates indicating when reviews are due and introduce regular audit of these.
2. Managers should introduce regular audit of consent to treatment forms to ensure the forms legally authorise all the treatments prescribed and that entries are correctly documented.
3. Managers should ensure that any policy regarding restriction of access to telephones which applies to all patients should apply to everyone equally.
4. Managers should ensure that staffing of the ward is sufficient to accommodate the needs of all patients and not focus on those with greater clinical demands.

#### **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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