

## **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:** 24 January 2019

## **Where we visited**

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

This was an announced visit to the service. We last visited on 3 October 2017, and at that time we made recommendations relating to recording patients' views, promoting the use of advance statements, reviewing one-to-one contact in relation to risks, and patients' rights under specified persons guidance. We received a response regarding our recommendation in November 2017.

## **Who we met with**

We met with and/or reviewed the care and treatment of six patients. There were no relatives or carers that wished to meet with us on the day of the visit.

We spoke with members of the nursing team, the charge nurse (CN), the clinical nurse manager (CNM), the dietician, and the consultant psychiatrist.

## **Commission visitors**

Claire Lamza, Nursing Officer

Paula John, Social Work Officer

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

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

All of the patients that we met with told us that staff who work with them were helpful, supportive, informative, and provided direction and structure with treatment goals that helped in their recovery.

Those that we spoke to had different views and opinions about their care and treatment when in REDU. While some described their recovery journey as slow, and explained that being an inpatient had not been a positive step for them, others told us that they had chosen to be admitted, knowing that they would not recover to the same extent without inpatient treatment. We were informed about some of the restrictions that patients understood to be necessary as part of their treatment programme. While they found these to be challenging, they felt that staff discussed the rationale with them, and looked for alternative solutions where possible. We were able to observe this taking place during one of the meal sessions.

We also had an opportunity to meet with members of the clinical team, who explained some of the complexities in providing seamless care between in-patient and community settings for individuals with an eating disorder, who may have other

diagnoses that required treatment. We were advised that there is ongoing work with other service providers to review and develop the current model of care.

We could see some of the challenges that the clinical staff had when we reviewed the care plans. We were impressed with the level of detail in the plans, and with the assessments, formulations, and clinical notes. We saw evidence of the structured treatment approaches throughout all of the care plans that we reviewed. These were well organised and easy to navigate, as all sections were colour coded with content that was current, and reflected the detailed and person-centred care that was being delivered.

There was a useful ward round review sheet that provided details of the patients' weekly progress, and set out the objectives for the week ahead. We were made aware that, prior to this meeting, patients are invited to submit five requests for further discussion.

We reviewed treatment plans that covered the breadth of topics associated with the different needs of this group. Along with the patient's needs in terms of their eating disorder and mental health, there were treatment plans for physical healthcare, social and programme inclusion, and for restrictions such as restraint and specified person measures. While we noted that the template for needs and aims was standardised across patients, all of the interventions were personalised. We were pleased to see patients' signatures at the bottom of the treatment plans where they had given their agreement, and there was also a record of when the patient disagreed or declined to sign.

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

For the patients who were detained under the Mental Health (Care and Treatment) (Scotland) 2003 (Mental Health Act), we found the relevant paperwork relating to the Mental Health Act in the care plans. All of the care plans in REDU contain a Mental Health Act form that provides key details on the patient's status, and whether there is an advance statement or named person. Where a named person had been nominated, there was a copy of the witnessed form.

All forms for consent to treatment under the Act (T2), forms authorising treatment including artificial nutrition (T3 and T3b), and for urgent medical treatment (T4) were available in the care plan and in the drug prescription sheet for the patient. All of the forms that we reviewed were in date and covered the prescribed medication.

A previous recommendation was to ensure that when a patient is made a specified person that they were made aware of their rights. However, for those patients in REDU who had these restrictions in place, we found that it was still unclear whether the patient was aware of their right of appeal. Sections 281 to 286 of the Mental Health

Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. We would therefore expect restrictions to be legally authorised, and that the need for specific restrictions is regularly reviewed.

From the care plans we reviewed, we found the restriction had been legally authorised. However, evidence of the reasoned opinion and the appeal process, which should have been provided for the patient, was not documented clearly in the care plans for these patients.

Our specified persons good practice guidance is available on our website: [http://www.mwcscot.org.uk/media/216057/specified\\_persons\\_guidance\\_2015.pdf](http://www.mwcscot.org.uk/media/216057/specified_persons_guidance_2015.pdf)

### **Recommendation 1:**

Managers should ensure specified persons procedures are followed.

### **Rights and restrictions**

As part of the treatment regime in REDU, there are specific criteria set out for those who are admitted in terms of weight, mealtime, and activity management. Whether a patient is informal or formally detained for their treatment, we would expect them to be informed of 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/rights-in-mind/>

For those patients that requested it, there was involvement with advocacy and legal representation, and this was recorded in their care plans. However, we found that patients who were informal were not clear on their right to leave or have time off ward.

### **Recommendation 2:**

Managers should ensure that patients are made aware of their rights, and that this is clearly documented.

On reviewing the risk assessments, and the associated management plans, we found that not all contained up-to-date information. We also noted that for those patients who were on constant observations, or who required staff to observe them at times when risks were considered to be increased, for example after mealtimes or when exercising, there is not a positive response to managing risks.

This issue was raised in the last report and the service response indicated that a series of actions were to be put in place. Further work is recommended, using the pending guidance from Health Improvement Scotland <https://ihub.scot/project-toolkits/improving-observation-practice/from-observation-to-intervention/>

### **Recommendation 3:**

Managers should develop positive risk taking strategies and plans for patients whose risk requires increased intervention.

### **Activity and occupation**

The unit has a full multi-professional team who are all involved in delivering psycho-social, psycho-educational, and psychological interventions, ranging from low to high intensity therapies. Since our last visit there has been an increase in the provision of occupational therapy and psychology services to support the activity programme.

We were pleased to see a broad range of activities on offer. These included the menu group “cooking to eat”, a nutrition group, cooking skills, and dietetics, all provided by the dietician. Those that we spoke to were very positive about the support and input they had received from this service.

Other groups that were available included body awareness, relaxation and exercise management with the physiotherapist; mindfulness/meditation and the schema group with psychology; and arts and crafts, the self-care group, and cognitive remediation with the occupational therapists. The nurses deliver groups in goal setting, mood box, head space, social art, challenge, and the community meeting.

Psychiatry and psychology provide individual therapy sessions for patients, and there is access to art therapy.

We found evidence of patient engagement in activities recorded on a specific form in the care plan, and we were able to see at a glance which groups and sessions the patient had attended.

### **The physical environment**

The ward has a calm and relaxed feel, with a large spacious communal area and numerous well-lit and tastefully decorated rooms for patients to access, including the main day room and family room. All 12 rooms on the ward are en suite, and there is a large kitchen where we observed the patients and staff sharing mealtimes. There is an OT kitchen and group room for therapeutic activities, and access to the garden area is available when a patient requests this. However, we noted that there is no dedicated area solely for staff.

### **Any other comments**

When we met with the members of the clinical team, we were informed that there have been recent changes with the senior nursing team. The CNM, senior charge nurse,

and CN have recently taken up their posts. The CNM explained that, as well as the planned session to look at the model of care for the service, there will be opportunities for staff to develop their clinical skills and their personal development plans.

We were also advised that there are some challenges in managing the differing needs of the patient group. We were told that where the focus is primarily on a patient's eating disorder, care and treatment has a more active recovery. Where the focus is on behavioural responses, this presents a greater challenge in supporting the patient's recovery. It is hoped that the planned model of care event will help develop strategies to address this.

## **Summary of recommendations**

### **Recommendation 1:**

Managers should ensure specified persons procedures are followed.

### **Recommendation 2:**

Managers should ensure that patients are made aware of their rights, and that this is clearly documented.

### **Recommendation 3:**

Managers should develop positive risk taking strategies and plans for patients whose risk requires increased intervention.

## **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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