Mental Welfare Commission for Scotland

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

Date of visit: 2 July 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 Eden Unit is a mixed-sex, 10-bedded, specialist eating disorder unit based in Royal Cornhill Hospital.

On the day of our visit, there were 10 individuals in the ward, eight of these individuals had an eating disorder diagnosis, and two were boarded from other wards in the hospital but were out on pass and expected to be discharged.

The unit is a regional service for the North of Scotland and accepts referrals from Tayside, Grampian, Highlands, Orkney, Shetland, and the Western Isles. The eating disorder service also provides a day provision programme that supports individuals in the community.

There were four spaces on the day programme, which were solely for NHS Grampian individuals, and we heard about how this facility had supported individuals as part of discharge planning and prevention to hospital admission.

We last visited this service in March 2024 as an announced visit and made recommendations on the auditing and review of care plans and ensuring consistency in the recording of notes which were held in both paper and electronic format.

The action plan that we received from the service provided details as to how the service was going to meet the recommendations.

For this visit, we wanted to follow up on the previous recommendations, look at individuals' experience of being in the unit and see the progress of the planned development of the garden area we had heard about on our last visit.

Who we met with

We met with six people and reviewed the care records of five of them. We also reviewed the care records of another person. We did not speak to any relatives or carers.

We spoke with the senior charge nurse (SCN), nursing staff, a student nurse, the associate specialist doctor and consultant psychiatrist.

Commission visitors

Susan Hynes, nursing officer

Kathleen Liddell, social work officer

What people told us and what we found

Since our last visit, we have heard that there has been a new senior charge nurse and two deputy charge nurses. These were experienced nurses and staff told us they felt there was good leadership in the nursing team which had had a positive impact on staff retention and consistency of care. Individuals we spoke with who had previous admissions to the Eden Unit agreed with this and felt the nursing team provided consistent and person-centred care.

Most people we spoke with told us of feeling fully involved in their care and of being listened to. They appreciated the skilled, knowledgeable input that was offered by the multidisciplinary team (MDT). We heard how people valued the input from occupational therapy (OT) and physiotherapy in supporting activities on the unit and in supporting people engage in community outings.

We were told that individuals could attend their MDT meetings and reviews; those people we spoke with agreed with this and reported that if they were not able to attend, they received feedback from nursing staff and generally felt their views were fully considered.

One person we spoke to felt that some nurses were not as supportive of them, particularly at mealtimes. They had discussed this with the SCN but felt this had not been fully addressed. People we spoke with who were seen by the nurse therapist talked of valuing this input and finding it very helpful.

People told us the ward was generally a quiet, settled place where they felt safe. We were told there were areas where they could have visitors or enjoy some quiet time if they wanted.

Several of the people we met with had been diagnosed with or were being assessed for autistic spectrum disorder (ASD). They told us staff had a good awareness of neurodiversity and made appropriate adjustments to their care and the environment. We heard how the PEACE pathway was used in the unit; this is an autism-informed treatment framework that had been developed from clinical experience, specifically for autistic individuals who suffer from an eating disorder.

We heard from several people that the ward could be stuffy, particularly the side rooms where the windows could not be opened, so there was a lack of ventilation. One person had requested to move to the dormitory because of this.

The people we spoke with received information before they were admitted and felt this had helped them know what to expect. They also received guidance about expected behaviour and rules in the unit on admission. Some people we spoke with had questioned some of these (such as only brushing teeth twice a day and eating all food stuffs together during the meal) and had been satisfied with the explanation

they received from staff. We heard staff used a flexible, person-centred approach to these rules.

Staff we spoke with indicated that they enjoyed working in the unit and felt there was good educational and development opportunities. We heard that since our last visit the consultant psychiatrist had left, and a locum consultant psychiatrist has since been employed. There had been a gap between the consultant psychiatrist leaving and the locum consultant psychiatrist starting which had been challenging, but all agreed that in the last few months, the unit had felt more settled.

Care, treatment, support, and participation

Care records

Care records were held on the electronic system TRAKCare, and each person also had a paper file which contained paper-based assessments, copies of Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) paperwork, some psychological formulations and rapid risk assessments.

In addition, there were meal plans and meal support plans for the dining area as well as a continuous intervention (CI) folder that contained a detailed plan for supporting stressed and distressed behaviour and interventions the person found helpful.

Care plans were also held on the electronic records system.

We were told that all of the MDT recorded their daily contact with individuals on the system and the weekly MDT meetings were also being recorded on TRAKCare.

We found the system easy to navigate and were able to find information easily. We found paper records, which held significant amounts of person-centred information, and some paper care plans which had not been transferred into the electronic care plans.

Most care plans we reviewed were well structured with plans identifying needs, agreed goals and interventions to meet these goals. Some lacked detailed, personalised information about the specific interventions that were required to meet identified need and these contained more generic interventions which were generalised and not specific to the individual's circumstances, reducing the person-centred nature of the care plans.

If the information contained in the assessments and care records had been transferred into the care plans, it would have strengthened the content and ensured care was delivered in the best way for the person.

We found some individuals did not have care plans where we would have expected the interventions to be detailed in a care plan. Where there was restrictive practice taking place, such as restraint or nasogastric feeding, a care plan should have been

in place to support staff to carry out these interventions in a consistent, person-centred way. We saw evidence in the care records that this was being done, but unfortunately care plans were not in place to support this.

We saw evidence in the records that we reviewed of individual involvement in the care planning process; examples of this were where it had been documented that a person had been given a copy of their care plan and people we met with told us that they had agreed their goals.

Care plans we viewed had been reviewed weekly, but reviews mostly recorded that 'no changes were required'. However, we also saw evidence that progress was monitored and that appropriate adjustments were made to the care plans as individuals' needs changed.

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.

Recommendation 1:
Managers should undertake an audit of care plans to ensure that they address all individual needs, are consistently reviewed, and clearly record progress in relation to recovery-focused goals.

Risk assessments and risk management plans were held on TRAKCare with a rapid risk assessment held in the paper record.

In the care records we reviewed, we found that risk assessments had been completed for individuals but in some cases the assessment focussed on the risk of poor food and fluid intake and the risk to physical health. Historical risk of suicidal ideation or self-harm had not been considered and completion of risk management plans to manage the identified risks was inconsistent.

Some individuals did not have a full risk assessment or a comprehensive risk management plan, with the latter ensuring that risks were actively mitigated through consistent multidisciplinary actions, clear roles and responsibilities, and person-centred strategies. A comprehensive risk management plan supports continuity of care, reduces reliance on restrictive interventions, promotes recovery, and provides defensible, transparent decision-making that protects individuals, staff, and the organisation.

Recommendation 2:
Managers should undertake an audit of risk documentation to ensure that each risk is identified and information on the management of them is clearly recorded.

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

Multidisciplinary team (MDT)
The unit was supported by a full MDT with various professional backgrounds including nursing, medical, OT, physiotherapy, dietetics, psychology and pharmacy, with speech and language therapy available by referral if required.

An individually tailored treatment programme was delivered by specialist staff, who were specifically trained in eating disorders. We saw detailed formulations completed in the first few weeks of admission, which identified outcomes and plans as part of the person's recovery. The therapeutic approaches consisted of dialectical behavioural therapy, mentalization-based treatment, interpersonal therapy, family-based therapy, and art therapy. Other interventions and treatments including practical skills, such as meal portioning and meal preparation were also available.

We found that there was good input with regards to physical health care and monitoring. We were aware that the service had a protocol in place for the management of individuals with severe and acute anorexia nervosa, who required to be admitted to a medical ward, either prior to or during admission to the Eden Unit.

The MDT told us that the unit had a clear admission pathway and referral protocol, where the referral would be initiated by the NHS Grampian consultant psychiatrist and those individuals who required to be admitted due to their acute medical needs would go to Ward 104 in Aberdeen Royal Infirmary.

We heard that individuals met with their key nurse prior to the weekly MDT meeting to discuss progress from the previous week and discuss any requests. These requests were written on a 'request form' for the MDT's consideration. The request forms we reviewed contained a variety of requests relating to time out of the ward, access to bathrooms and other aspects of care in the unit.

The feedback from most of the individuals we met with was that they felt involved in their care and generally felt their views were considered. In some instances, people we spoke with disagreed with the decisions made but still felt they had been involved in the discussion and decision-making process regarding their care and treatment.

We were told by individuals that nursing or medical staff would provide feedback as to whether their requests had been agreed by the MDT and the rationale for this. We heard and saw that individuals were given a written feedback form from the meeting.

We did not find that the recorded information in the care record provided a comprehensive rationale as to how the MDT had reached their decision, although the ongoing plan was recorded. We raised this with the SCN on the day of the visit and were told a more comprehensive account would be recorded moving forward. A more in-depth review was held every six weeks and this allowed for a fuller

discussion and included the person, their family/carers and community team members, as appropriate.

We heard from staff and individuals about the close links with the community eating disorder teams in the local areas the unit served. The staff from these teams kept in contact with individuals while they were in the unit and attended the MDT and discharge planning meetings. We heard how this supported the transition for people into and out of the unit.

Use of mental health and incapacity legislation

On the day of the visit, three people were detained under the Mental Health Act. The individuals we met with during our visit had a good understanding of their detained status, where they were subject to detention under the Mental Health Act. They told us they had received written information about this and were aware of their rights around appeal.

Some people we met with on our visit who were receiving their care on an informal basis had been advised of their rights, whereas others we spoke with appeared unclear about what rights they had, although it appeared from their records that this had been discussed.

We were satisfied that any restrictions that were in place for people admitted informally were underpinned by the person's consent, with a clear rationale recorded in the clinical documentation. We saw that restrictions were subject to regular MDT review to ensure they remained necessary, proportionate and rights based.

We discussed with the MDT that where an individual's consent fluctuated or was withdrawn, any restrictions should be reviewed more frequently. In such circumstances, consideration should be given to the person's capacity to consent to the restrictions and whether assessment under the Mental Health Act was required. This helps to ensure that any ongoing restrictions are supported by an appropriate legal framework, protecting the individual's rights while authorising any necessary restrictions.

Anybody who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where an individual had nominated a named person, we found this was documented in their records and their named person was included appropriately. We saw this was revisited regularly with the person.

All documentation relating to the Mental Health Act was available in the ward, with copies in individuals' paper file and in a Mental Health Act folder in the ward. Information was easy to find, well organised and relevant.

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 and corresponded to the medication being prescribed.

We found that although the certificates were in place and all medication was legally authorised, there was an old copy of a T2 certificate in one person's file and in the Mental Health Act file. This did not correspond to the medication that person was prescribed. We queried this on the day and asked how nursing staff, who were dispensing and administering medication, assured themselves that the correct legal authority was in place; we did not receive assurance that an appropriate system was in place.

We discussed this with the SCN on the day and received assurance that the correct certificate had been placed in the files and that a file for T2 and T3 certificates would be held beside the electronic prescribing system to allow nursing staff to check appropriate authority was in place prior to administering medication. We also suggested a regular audit of the paperwork would be prudent.

Rights and restrictions

The Eden Unit continued to operate a locked door, commensurate with the level of risk identified in the ward population. A locked door statement was displayed on the outside door, and a copy of NHS Grampian locked door policy was displayed at the entrance.

We were aware from speaking to individuals and staff that some individuals' bathroom doors were locked at specific times of the day, usually on admission to the unit. The SCN told us that the locking of a bathroom door would only happen in the en-suite rooms and not the dormitory.

We spoke with individuals who were aware of this routine and they told us that this was discussed with them on admission and included in their care plans. We saw there was a flexible approach and this had not happened for all individuals we reviewed.

Information about restrictions in the unit was provided in the information leaflet, and we saw recordings in care plans and the care records of discussions relating to these, which had taken place at the time of admission and then followed up in MDT meetings.

We discussed with the SCN and speciality doctor about individuals' rights when they were receiving their care informally and were not happy with the level of restriction in place. We were satisfied that there were regular reviews in place regarding

restrictions and that individuals views were sought at various times, whether they were detained or informal.

We saw evidence of restrictions being reduced following reviews in individuals' notes. The unit had considered a voluntary admission contract for an informal person to sign on admission; this had been discussed at our last visit. The service had decided against introducing this and instead worked at agreeing aspects of care and treatment with each person on admission, which provided a more person-centred, rather than a blanket approach to restrictions.

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 an individual is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. There was no-one who was specified on the day of our visit and there were not any restrictions placed on individuals that would require this.

We were pleased to see information on rights on display in the Eden Unit. We saw that information on rights was included in the pre-admission pack, with contact details for advocacy. A twice weekly community meeting took place in the unit and there was a suggestion box with staff reviewing the suggestions made on a regular basis.

We heard from most individuals that we spoke with that they found this meeting supportive and useful, with changes and ideas being taken forward and implemented. Some individuals told us they had raised some unit issues at the community meeting and found that the forum, facilitated by staff, had enabled them to find solutions to the issues they were experiencing.

Intermittent CI was in place for one individual. We reviewed the documentation for this individual and were able to find a care plan and MDT documentation that recorded the purpose for implementing CI and the review of this. We found that CI information was recorded in the daily care records and we were able to find documentation that recorded clear decision making as to why CI was required and regular reviews to assess its effectiveness in reducing risk.

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 did not find any statements although we saw in people's records that these were discussed and the individuals we spoke with were aware of these. We also saw information in the ward promoting advance statements. We were told advocacy

services were available and individuals confirmed they were aware of advocacy and had been offered to meet with them. However, they were not fully aware of the function advocacy services provided and we felt that more information about the advocacy services would allow individuals to make a more informed choice about their involvement. We discussed this with the SCN on the day and she agreed to invite advocacy services to regularly attend the community meeting to discuss their role with people in the unit.

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. We saw this information displayed in the ward area.

Activity and occupation

The unit had an activity programme displayed on the wall in the corridor, and we were told that the OT and physiotherapist delivered most of the group activities daily, Monday to Friday.

Nursing staff told us that it was beneficial having those professionals dedicate time for activities, as this enabled them to concentrate on the nursing aspects of the individual's care and treatment.

Individuals were able to tell us about the groups and the one-to-one sessions with therapists, and what activities they were involved in as part of their recovery and how they benefitted from these. We saw artwork displayed on the wall in the lounge area that individuals had completed, and we heard from individuals that they found drawing and painting very therapeutic.

We found a record of activities in individuals' files and also where a person had been offered but had declined to participate in an activity. Where we heard from individuals that they preferred one to-one activities, we saw this was facilitated and an individualised approach to activity planning was evident.

We were told that there were regular community meetings on the unit and there was a book in the lounge area where individuals could make comments and suggestions about specific issues on the ward such as improvements, meetings, activities.

One person we talked to told us there could be less to do at weekends when the OT and physiotherapy staff were not working; however, we saw there were some weekend activities recorded in the care records.

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

The physical environment

The Eden Unit had six single rooms that all had individual bathrooms. Each room had a bed, storage shelves or a wardrobe for individuals to store their belongings.

Several individuals told us that their bedrooms became uncomfortably hot and stuffy because the windows could not be opened. Some reported requesting to move to the dormitory, where the windows could be opened, to access fresh air and a more comfortable environment. Access to adequate ventilation and fresh air is an important aspect of a therapeutic care environment, and we were concerned that individuals were unable to achieve this in their own bedrooms.

We also noted that portable fans had been provided in some rooms to mitigate the heat however, these introduced potential ligature risks. We discussed with the service the need to identify a safer, longer-term solution that ensured individuals had access to adequate ventilation while maintaining a safe environment.

There was a dormitory that had capacity for four individuals, with a shared bathroom, and similar furniture for storage. There was also a larger bathroom in the unit.

The unit had shared areas that supported individuals to socialise and that were used for groups. An area in the communal lounge provided a snug area for individuals who wanted some quiet space out with their bedroom. The communal lounge area was the area that individuals used for post-meal supervision. The lounge area provided plenty of seating and a warm environment.

There was a kitchen in the unit, where portioning and meal preparation took place. The dining area was attached, where individuals attended for all meals and snacks. We were told that some individuals would cook with staff in this area. There was a visitor's room which had comfortable seating, a television and a colourful wall display that had been developed by nursing students which had helpful information and resources for carers.

The unit was in good decorative order and the people we met with commented how clean the ward was and that they appreciated the efforts of the domestic staff.

We wanted to follow up on the outdoor garden area, as we had been concerned about the lack of progress on the planned work in the garden since our themed visit in 2019. Access to the garden area was via the communal lounge area and we had previously been told that carers had raised funds to support the development of this area, but there had been no progress.

The advocacy service had been in contact with the Commission about this previously, and we had been told quotes had now been received for the works, and that plans had been drawn up. We were very disappointed to find no progress had been made, as there had been a need for the work to be quoted for again by another

contractor and we heard that this quote was not felt to be suitable and progress had halted. We raised this with the service manager and were told that the money raised had been ring fenced for the garden work and an application has been made to progress this once again.

Individuals receiving care should have access to safe, therapeutic outdoor space as part of their recovery and wellbeing. The prolonged inability to progress this project suggests that organisational processes and systems have created barriers to delivering this important aspect of the therapeutic environment.

We discussed with the service the need for a more proactive approach to ensure these longstanding obstacles are addressed and that individuals are not deprived of the benefits of access to an appropriate outdoor therapeutic space because of avoidable delays.

Recommendation 3:
Managers should address the deficits in the physical environment and formulate a plan to ensure the accommodation promotes a safe environment, while providing adequate ventilation.

Recommendation 4:
Managers must ensure that the garden area is developed in a timely fashion, according to the approved plans.

Good practice

It was positive to note that in May 2026, the Mental Health and Learning Disabilities Services (MHLDS) achieved a Pathway to Excellence® designation from the American Nurses Credentialing Centre (ANCC). The services became the first organisation in Scotland to receive this recognition, and the first service in Europe, which is a considerable achievement. The ANCC Pathway recognises healthcare organisations that commit to create a practice environment where nurses feel supported, valued, and empowered.

On the day of our visit, we observed excellent nursing leadership in the Eden Unit which appeared to be delivering positive outcomes for both individuals and staff.

Summary of recommendations

Recommendation 1:
Managers should undertake an audit of care plans to ensure that they address all individual needs, are consistently reviewed, and clearly record progress in relation to recovery-focused goals.

Recommendation 2:
Managers should undertake an audit of risk documentation to ensure that each risk is identified and information on the management of them is clearly recorded.

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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.

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