Mental Welfare Commission for Scotland

Report on announced visit to: Blair Unit, Royal Cornhill Hospital, Cornhill Road, Aberdeen, AB25 2ZH

Date of visit: 5 November 2019

Where we visited

The Blair Unit comprises the intensive psychiatric care unit (IPCU), forensic acute, and forensic rehabilitation wards. The IPCU has eight mixed-sex beds. The forensic acute ward is a low-secure acute forensic psychiatry ward for male patients with eight beds. The forensic rehabilitation ward is a low secure forensic psychiatry inpatient rehabilitation unit for male patients with 16 beds.

We last visited this service on 7 August 2018 and made recommendations about care planning, activities, and ward maintenance.

On the day of this visit we wanted to meet with patients and follow up on the previous recommendations.

Who we met with

We met with and/or reviewed the care and treatment of 13 patients and two relatives.

We spoke with the service manager, the charge nurses and consultant psychiatrist.

Commission visitors

Douglas Seath, Nursing Officer

Tracey Ferguson, Social Work Officer

Paula John, Social Work Officer

Lesley Paterson, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Patients generally reported good support from staff, and nurses were described as interactive and approachable. Staffing generally was at full complement and wards had a varied team in terms of experience and gender which worked well. We found some detailed and person centred care plans but a few of a more generic type. Reviews were indicated by date and signature only without a summative evaluation. This was an issue identified on our previous visit and has not been addressed. Risk assessments were comprehensive and progress notes detailed one-to-one time with nurses. Restraint was recorded on datix and highlighted in the notes, and then audited. Recorded evidence of feedback or follow up with patients or staff after incidents of restraint did not appear to be documented.

There was evidence of 'core care plans' being used as templates with one in particular having the incorrect patient's name used throughout the interventions. Further, we could find no evidence of summative evaluation. Most reviews were only signed and dated with no text. There was also limited patient involvement in reviews, one record giving the reason for lack of signature due to the patient being asleep.

The Commission has published a good practice guide on care plans. 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, and can be found at:

https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

There was a treatment plan with had been compiled by the psychologist and the psychiatrist called "Reactive Strategies for managing episodes of challenging behaviour." It was positive and gave staff a lot of detail and practical strategies for managing patients with complex needs. Nursing note entries were detailed and relevant, and there was clear evidence of frequent one-to-one sessions.

Rapid risk assessments are completed on admission and the risk profile contained within the patient care document is completed within two hours and reviewed within 72 hours. Patients who require an HCR-20 or other risk assessment have these carried out in due course. All risk paperwork appeared thorough, detailed, and highlighted relevant risk areas.

A single weekly multidisciplinary team (MDT) meeting takes place and encompasses all three wards. The meeting lasts for three hours and each ward has a one-hour slot. Patients are not invited to the meeting but can request to see their consultant at another time. Nursing staff meet with each patient before and after the meeting to check if the patient has anything they wish to be discussed, and to provide feedback after the meeting. Although the Senior Charge Nurse (SCN) gave assurances that these meetings take place, they were not well evidenced within the notes. Additionally, the MDT record sheets are incomplete and there is no way of knowing who attended each meeting.

Some patients were subject to Care Programme Approach (CPA) & Multi Agency Public Protection Arrangements. and these were well documented in files.

Physical healthcare needs appear to be adequately addressed. Patients can also be referred to physiotherapist, dietician, dentist and speech and language therapist if required. There is a gym on site which some patients use.

Recommendation 1:
Managers should ensure that nursing staff include summative evaluations in patient care plans that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

This issue was identified on the previous visit and has not been addressed, we will raise this with senior

Use of mental health and incapacity legislation

Part 16 (s235-248) of the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. The authorising treatment forms (T3) completed by the responsible medical officer to record non-consent were mostly in order as appropriate. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were also in place where required. One or two minor issues with forms were dealt with on the day of the visit.

Sections 281 to 286 of the Mental Health Act provide a framework within 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. The Commission would therefore expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed.

When the responsible medical officer (RMO) has determined that room searches are required for this purpose, they should make the patient a specified person for safety and security in hospitals under s286 of the Mental Health Act. This is necessary to provide legislative authority for this restriction. It also provides the appropriate framework for review of the restrictions and the patient with their right to appeal against these.

Patients had access to advocacy and legal advice. We found evidence of the reasoned opinion in the care plan and that the patients had been informed about their right of review.

All patients in the forensic rehabilitation ward were subject to specified person status for safety and security. All paperwork was in order and reasoned opinions were documented for each individual. Documentation in the other wards was similarly in place with one exception which was dealt with appropriately on the day.

Rights and restrictions

Aberdeen Advocacy Service is based on the hospital site and is well used by the patients. The advocacy staff are in the wards most days, seeing patients. The advocacy service also run a monthly patients community meeting which is well attended.

Advanced statements do not seem to be well promoted. Most patients did not have one and although this is asked about on admission, there does not appear to be any further review of this or encouragement to complete them.

Rights-based information was not readily available for patients. Some patients were not clear about their rights and asked about extension of orders and whether they could be forced to take medication. No patients appear to have made advance statements and some staff were unclear where to locate paperwork and if it was their role to promote them.

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-mind/

The Commission has also developed a good practice guide on supporting people to make advance statements and how they are used. This can be found at:

https://www.mwcscot.org.uk/media/128044/advance_statement_guidance.pdf

Recommendation 2:
Managers should ensure that staff are familiar with their role in promoting the use of advance statements and providing patients with information and assistance with this.

Activity and occupation

Activities on the ward were limited but were available at the recovery centre, and those that had time off the ward were getting out regularly. There were attempts to follow the new observation guidance in relation to continuous interventions, as evidenced in the case of one patient who staff spent time engaging in activity as opposed to being observed from outside her room.

There are two occupational therapists and two technical instructors allocated to the wards and they compile a weekly activity planner. Each patient has a named nurse and an allocated nursing assistant who are also responsible for planning activities with them. There is also access to a games room with a pool table, games console and TV & DVD player.

The physical environment

The ward accommodation is a combination of side rooms (none of which are en suite) and two four- bedded dormitories. There is an adequate number of shower rooms and bathrooms, all of which have a toilet.

There is a medium sized enclosed garden which is unlocked during the day and is generally well used by patients. In the better weather, the garden is used for barbeques and sports, etc.

There seemed to be a shortage of armchairs in some areas with patients having to sit on upright dining room type seats, and interview space was limited. The showers in the rehabilitation ward were in poor condition with no ventilation, evidence of mould, potential ligature points, poor decor and a trip hazard.

Recommendation 3:
Managers should ensure that outstanding repair and refurbishment work is undertaken as soon as practicable.

Any other comments

Nursing staff have to facilitate escorted smoking breaks outside the hospital grounds for patients. Currently most patients have escorted time off the ward and choose to use for smoking purposes. This is a considerable amount of time that staff are off the ward and has an impact on the availability of staff to facilitate other patient activities. Staff are currently considering how best to address this.

Summary of recommendations

1. Managers should ensure that nursing staff include summative evaluations in patient care plans that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.
2. Managers should ensure that staff are familiar with their role in promoting the use of advance statements and providing patients with information and assistance with this.
3. Managers should ensure that outstanding repair and refurbishment work is undertaken as soon as practicable.

Good practice

The SCN in the acute forensic ward told us that over the past two years there has been a significant reduction in the number of reported incidents of restraints. Reasons identified for this include changes in observation practice, staff training, and the introduction of the 'clinical pause'.

A member of staff is assigned to be present in the communal area at all times. They are deemed the 'immediate responder' and are available to respond to any incidents that may occur in the day room, corridors, garden or games room.

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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