**Mental Welfare Commission for Scotland**

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

**Date of visit:** 26 October 2021

## Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's route map (May 2020). There have been periods during the pandemic where we have been able to conduct our face-to-face visits; however, the reinstatement of lockdown required us to review this, and we are presently undertaking a variety of face-to-face and/or virtual visits. This local visit was able to be carried out face-to-face.

The Blair Unit comprises of the intensive psychiatric care unit (IPCU), a forensic acute ward, and forensic rehabilitation ward. The IPCU has eight mixed-sex beds and on the day of our visit there was seven patients on the ward. The forensic acute ward is defined as a low-secure acute forensic psychiatry ward for male patients and has eight beds. The forensic rehabilitation ward is a low secure forensic psychiatry inpatient rehabilitation unit for male patients with 16 beds. Both forensic acute and rehabilitation wards were full on the day of our visit.

Managers told us of the ongoing staffing challenges regarding recruitment, along with the added complexity of the pandemic that they have been faced with over past year and continuing to do so. Managers told us that as part of the ongoing daily contingency plan there continues to be a daily huddle each morning, across all service areas, to address staff shortages and bed provision.

We last visited this service on 5 November 2019 and made recommendations about care planning, advance statements and ward maintenance.

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

## Who we met with

We met with and reviewed the care and treatment of 12 patients and spoke with one relative.

We also met with the service manager, the senior charge nurses (SCN), ward staff, consultant psychiatrists and the occupational therapist (OT). Contact was also made with advocacy service.

## Commission visitors

Tracey Ferguson, Social Work Officer

Anne Buchanan, Nursing Officer

Alyson Paterson, Social Work Officer

Kathleen Liddell, Social Work Officer

Graham Morgan, Engagement and Participation Officer

Dr Juliet Brock, Medical Officer

# What people told us and what we found

## Care, treatment, support and participation

Feedback from the patients was generally favourable about their stay in hospital. Most patients told us that they felt safe in the ward environment, and spoke positively about the staff who supported them. Where a patient was distressed, we observed staff responding promptly to support the patient. We saw interactions between staff and patients which were warm and supportive. In speaking to staff, it was evident that they knew the patients well.

On the day of our visit, we heard about patients being in ward environments that did not meet their needs although this was followed up at the time. The wards continue to have a member of staff assigned to be present in the communal area at all times on each ward. They are identified as the 'immediate responder' and are available to respond to any incidents that may occur in the day room, corridors, garden or games room.

We found detailed mental health assessments, along with risk assessments that were comprehensive and completed on admission. All risk paperwork appeared thorough and highlighted relevant risk areas. We discussed a specific risk assessment for a patient, as it was unclear if it had been reviewed/updated. The consultant told us that this specific assessment may be held electronically and agreed to look into the matter. We found evidence of good physical health care checks and were told that ward has regular access to GP. One-to-one time with nursing staff was recorded in the patients' notes, most of which was detailed; however, we saw language in patient files that was not person-centred. We discussed this with the SCN on the day of the visit.

We were told that there is a weekly multidisciplinary team (MDT) meeting that takes place via Microsoft teams and covers all three wards. Patients are not invited to the meeting but can request to see their consultant at another time. We were told that nursing staff meet with each patient prior to and after the MDT, to check if the patient has anything they wish discussed, and to provide feedback after the meeting. The minutes of the MDT were variable. The nursing staff take a record of the meeting, as do the consultant psychiatrists. We found that there was more detail in the medical notes than the nursing MDT record. It was also unclear as to who provides feedback to the patient following the meeting.

We heard that there is psychology and occupational therapy (OT) dedicated to the wards and all wards have input from pharmacy. From reviewing the patient's files it was not always clear which professionals were involved in the patients care as files were not integrated. We were told that allied health professional (AHP) records are kept separately. Currently all notes are paper files, however we were advised that NHS Grampian is looking to implement an electronic recording system at some point in the future, but currently there is no timescale.

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

We heard that there are patients in the rehabilitation ward where their discharges have been delayed, and in further discussion with staff on the day, we were made aware of other patients who were ready for discharge but not recorded as being delayed; we discussed this with

managers and consultant psychiatrists. There are clear guidance from Scottish Government about the reporting of patients who are identified as delayed discharges in hospital settings, and therefore we would expect that where this occurs a health board records this in accordingly.

We wanted to follow up on our last recommendation regarding care planning. We found some detailed and person centred care plans but these were variable across all three wards. Some care plans lacked evaluation and reviews, and there was limited evidence of patient participation throughout some of the documentation. Some care plans were signed, but some had recorded that the patient was unable to sign, with no evidence that this had been reviewed and discussed again. We advised staff that opportunities to promote a patient's participation with their care plan should be encouraged when patients were able to engage.

We asked the managers for feedback in relation to the quality improvement project that we were advised about, in order to address our last visit's recommendations. SCNs told us that they have begun to audit case files more regularly but this has just started recently; we heard that the delay was due to the pandemic. Given that there was no significant improvement on this visit following on from the previous recommendations on care plans, we will follow this up.

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

**Recommendation 1:**

Managers should ensure that nursing documentation records the patient involvement and participation.

**Recommendation 2:**

Managers should ensure that delayed discharges are identified and reported through the relevant system.

## Use of mental health and incapacity legislation

All patients across the three wards were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') or Criminal Procedures (Scotland) Act 1995. Mental Health Act paperwork was in good order in the files we reviewed.

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. Our medical officer reviewed all of the relevant patient treatment forms, along with medication prescription kardex. We found some issues with the treatment forms, (T2 and T3) that had

been completed by the responsible medical officer (RMO) to authorise treatment under the MHA.

Patients who are prescribed clozapine or high dose antipsychotic medication should have appropriate physical health monitoring in place which is regularly reviewed. We did not find up to date clozapine/high dose monitoring forms for all patients who required them. The ward has input from pharmacy and therefore treatment forms should be reviewed as part of the MDT process, along with advice from pharmacy as part of monitoring process. We followed up the issues with patients' treatment on the day and will continue to follow these up with the designated RMO for each patient.

Where patients had nominated a named person we found evidence of this in files. We wanted to follow up on our last recommendation in relation to advance statements. We found that the uptake continued to be low, and there was no evidence that these were being promoted in the wards.

**Recommendation 3:**

Managers should ensure that all forms that record treatment are current, and authorise treatments appropriately.

## Rights and 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 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 to be regularly reviewed. It also provides the appropriate framework for the review of the restrictions and informs the patient of their right to appeal against these. We found that some of the specified person paperwork, was not in order, with no evidence of reasoned opinion documentation. For some patients it was unclear regarding their specified person status when we asked the nursing staff, although this was followed up with the RMO after the visit.

When the RMO has determined that room searches are required, they should make the patient a specified person for safety and security in hospitals under s286 of the Mental Health Act. Where we found that no paperwork was in place for this, we brought this to the attention of the RMO and SCN on the day of the visit, and will follow this up.

The advocacy service is based on the hospital site and is well used by the patients. We spoke with advocacy as part of the visit, and they told us that they continue to have good links with the Blair Unit. Although the advocates are not as visible on the wards as they were prior to the pandemic, we were told that advocates are continuing to have either face to face or telephone calls when necessary. Advocacy services are also involved in supporting patients in mental health tribunals and/or during review meetings.

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/law-and-rights/rights-mind

**Recommendation 4:**

Managers should ensure that for those patients where specified persons procedures are implemented that the relevant paperwork in completed and reviewed.

## Activity and occupation

During the visit, we spoke to the OT. We were advised that the unit has two OTs allocated to the wards, although at present there is only one OT and two OT assistants. However the service is currently recruiting for the vacant post, which we were told has been difficult to fill. We heard that some of these hours have been converted to OT assistant hours to support the shortfall in the interim. The OT told us about some of the challenges during the pandemic and how initially, OT activity decreased, however the service still managed to provide some activity programmes across the wards. There is a recovery resource centre situated in the hospital although we were told that the OTs mainly use the kitchen facilities in the unit, for rehabilitation purposes. The OT discussed with us about the use of the craft room in recovery resource centre as opposed to doing all activities in the unit.

In the rehab and forensic acute wards patients have access to a games room with a pool table, games console and TV & DVD player. We heard about a joint initiative with Aberdeen Health and Social Care Partnership (HSCP) where the unit has an adult learning tutor allocated for 12 hours per week offering learning opportunities for patients who cannot access resources in the community due to restrictions or offending behaviour.

The OT and OT assistants are involved in devising weekly ward based activities with staff and patients; there is also an activity nurse who provides activities across the unit

Although some community services have reopened, some are still doing remote working which can be challenging for this patient group. Some of the previously available community opportunities are no longer on offer, or being delivered in a different way.

## The physical environment

Accommodation across the unit consists of dormitories and side rooms, although none of these are en-suite. We saw that additional side rooms been made available in the rehab unit, in order to reduce the number of patients having to share a dormitory, due to the pandemic. Each ward has enclosed garden space which is generally well used by patients.

In the IPCU, the decoration and furnishings were tired looking and there were parts of the environment which appeared neglected in both communal and dormitory areas. The layout in both the forensic acute ward and IPCU also restricts observation, and for patients who were being nursed on continuous interventions, nurses were standing outside the bedroom door. In

the IPCU we heard from staff and consultants that there is no safe interview room or one-to-one space and that the quiet room offered no privacy. The environment has limited bathroom facilities and these are shared by male and female patients. We heard from other staff across the service that due to the Covid-19 restrictions there is now less space across the wards that has had an impact on patient privacy. We were told about staff concerns in relation to patient privacy and dignity when they are admitted to the ward from court.

We were informed about the ongoing concerns of female patients with forensic needs being cared for in the IPCU. There continues to be no forensic acute or forensic rehabilitation beds for female patients in the hospital, therefore some female patients may be placed inappropriately as there are no local female forensic inpatient services to meet their needs. The needs of patients with a forensic history can be markedly different from patients who are acutely unwell and require admission to an IPCU; those who require input from forensic services may require rehabilitation over a longer period of time, and as result of the current inpatient arrangements, may be receiving an inequitable service, in that they do not subsequently have access to the rehabilitation pathway.

We were concerned about the continued use of shared dormitory areas in the IPCU environment given that patients are acutely unwell; this does not offer privacy and dignity for patients. We also noted that although there has been some ligature reduction work across the three wards, there are ligature risks still evident in the wards.

We wanted to follow up on the last recommendation regarding the outstanding repairs. We were told that some repairs had been addressed however we were concerned that some had not been, specifically the mould in the bathrooms. Given that our last visit was in 2019 and works had not been completed we raised this with senior manager on the day, who made enquiries at the time and told us that this was being attended to as a matter of urgency.

**Recommendation 5:**

Managers should review the available accommodation to ensure the privacy and dignity of individuals are protected at all times.

## Any other comments

We heard from managers that there have been working groups set up to address the recommendations from the Independent Forensic Mental Health Review which was published in February 2021. We look forward to receiving more information as to how this work is being taken forward in NHS Grampian.

## Summary of recommendations

1. Managers should ensure that nursing documentation records the patient involvement and participation.

2. Managers should ensure that delayed discharges are identified and reported through the relevant system.

3. Managers should ensure that all forms that record treatment are current, and authorise treatments appropriately.

4. Managers should ensure that for those patients where specified persons procedures are implemented that the relevant paperwork in completed and reviewed.

5. Managers should review the available accommodation during the admission process to ensure the privacy and dignity of individuals are protected at all times.

## Service response to recommendations

The Commission requires a response to these recommendations within three months of receiving this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

SUZANNE MCGUINNESS
Executive Director (Social Work)

## 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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