Mental Welfare Commission for Scotland

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

Date of visit: 1 September 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

The Blair unit is based in the Royal Cornhill hospital and comprises of the intensive psychiatric care unit (IPCU), a low secure forensic acute ward, and a forensic rehabilitation ward.

Last year we visited all three wards in the Blair unit, however this time, we decided to only visit the IPCU. The IPCU is a mixed-sex, eight-bedded unit, and on the day of this visit, there were five patients in the ward. Managers told us that following our last visit, a decision was made to reduce the bed capacity to six. This was due to concerns that had been raised around accommodation and the lack of privacy and dignity for patients in the unit.

The IPCU is a locked unit and provides intensive treatment and interventions to patients who present with an increased clinical risk and who require a higher level of observation. Patients can be admitted via the courts due to criminal behaviour, or transferred from prison due to mental ill-health.

On the day of this visit we wanted to speak with patients, relatives and staff. We also wanted to find out how the ward was implementing the recommendations from the last visit in October 2021. Previous recommendations were regarding consent to treatment forms, patient involvement and participation, specified person legislation and accommodation.

Who we met with

Prior to the visit, we held a virtual pre-meeting with the senior charge nurse (SCN), clinical nurse manager (CNM), forensic clinical psychologist and forensic consultant psychiatrists.

On the day of the visit we spoke with the SCN, CNM, nursing staff, and consultant psychiatrists.

We met with, and reviewed the care notes of, four patients and spoke with one relative.

Commission visitors

Tracey Ferguson, social work officer

Anne Buchanan, nursing officer

What people told us and what we found

Care, treatment, support and participation

Throughout the day of our visit, we spoke with most patients in the unit. Some patients had recently been admitted, while others had been in the unit for a longer period of time. Feedback from patients about staff was mostly good. One patient told us that they felt safe in the ward, whilst another told us that they did not want to be in hospital. Patients described staff as supportive and caring, and one patient told us how they liked staff "checking in on them, to see they were ok" as they often found it difficult to express their feelings.

Some patients were able to tell us about their care and treatment, including their treatment for physical healthcare. All patients we spoke with either described the environment as awful or non-therapeutic.

The relative told us that they felt involved in their relatives care and that the staff and doctors were really caring, attentive and that the communication was good, however they described the environment as poor and not therapeutic, and that it had a negatively impact on staff and patient care.

During the day, we observed supportive interactions between ward staff and patients and from speaking to the staff team, we got a sense that they knew the patients well. Patients in the IPCU require intensive support and treatment, to assist their recovery during the most acute phase of their mental ill-health; due to the lower number of patients in an IPCU, along with a higher staff ratio, staff felt that they had the time to deliver care in a person-centred way.

The SCN told us about the ongoing staffing challenges in trying to fill vacant posts and we recognise that the recruitment of nurses is an issue nationally. The SCN told us about continued proactive efforts to recruit staff to vacancies and, more recently, three nursing graduates have been recruited into vacancies across the Blair unit. We were told that staff will work across the Blair unit, depending on clinical demand in each ward. At the time of our visit, the IPCU regular uses agency staff, to ensure safe delivery of patient care and continuity.

Nursing care plans

Of the patient files we reviewed, we saw detailed, holistic nursing assessments that were completed on admission, and updated appropriately. Risk assessment and risk management plans were in each patient's file, with evidence of ongoing review. Where patients were on an enhanced level of observation, we saw regular reviews taking place and reasons for either continuation or ceasing were documented.

Care plans were reasonably detailed and person-centred, including interventions and evaluation. We were aware that the unit uses the NHS Grampian booklet documentation that provides limited space for staff to record detailed interventions. However, we also saw detailed care plans that had been further developed where necessary, which we felt was positive. We wanted to follow up on our previous recommendation about patient participation and involvement. In files we saw evidence of one-to-one sessions between patients and staff, along with patient involvement in the care planning, where some had signed their care plans and others had refused.

We found good examples of person-centred physical and mental health care being provided throughout each patient's journey, with evidence of improvement in overall well-being. Some patient care plans were holistic and included a clear pathway for staff to follow should any deterioration in physical and/or mental health care occur. We felt that there was a real focus in the unit regarding the important correlation between poor physical and mental health care, and the impact that this may have on a patient's recovery.

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/node/1203

Multidisciplinary team (MDT)

There are three forensic consultant psychiatrists who cover the Blair unit. For patients who are admitted to the IPCU and do not have a forensic background, we were told that the day-to-day cover arrangements and monitoring of a patient's care and treatment is provided by the forensic consultants. However, we were told that a general adult psychiatrist (GAP) would still be appointed as the patient's responsible medical officer (RMO) where a patient is detained under Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

We were made aware that one patient in the ward, who did not have a forensic history, but whose presentation was complex, care and treatment was provided by the forensic consultant. We felt this was person-centred care, however this was not the case for all patients who did not have forensic needs.

We were told that the multi-disciplinary meetings (MDT) continue to take place weekly and the MDT consists of a consultant psychiatrist, nursing staff, occupational therapy (OT) and a forensic clinical psychologist. We were made aware that the OT and forensic psychologist only provide input to forensic patients in the IPCU. We were told if a patient who was not deemed to be a forensic patient required input from OT or psychology, then a referral would have to be made to GAP services. We are aware that there is no dedicated psychology for in-patient GAP services, and OT provision has been limited due to absence. We feel that this creates a disparity in care and treatment that is unfair and requires review.

In the MDT meeting record we saw that there was a recorded entry of who attended, with a detailed update for the meeting, along with information of any outcomes and actions. We were told that patients do not attend this meeting, although the consultant will meet with the patient before or after the meeting; the patient can discuss any issues relating to this meeting with the nursing staff. Where a patient's RMO was a GAP consultant, we were told that the consultant did not attend this weekly meeting.

We wanted to find out more about the MDT input, particularly where a patients RMO was not a forensic psychiatrist from the Blair Unit. The SCN and forensic MDT members told us that the GAP consultant would be invited to a review approximately every six weeks. We heard from staff that it was difficult and challenging where patients had different RMO's, other than the forensic consultants who are based in the Blair unit. We heard that when a patient no longer requires IPCU care, it can be difficult to transfer back to the general adult mental health services, due to bed capacity. Therefore, patients may remain in IPCU for longer than

necessary. We have heard from patients via our telephone advice line that they were often unsure who their consultant psychiatrist was or told us they had never or rarely saw their consultant while in IPCU. We were told that the forensic consultant liaises with the GAP consultant regarding changes to treatment. From our last visit we have had to follow up on specific cases where there were issues with treatment forms and restrictions placed on patients, however when contact was made with the RMO in the GAP services there was a real sense that they were not aware or had been involved in the decision making process regarding their patients care and treatment.

Recommendation 1:
Managers must develop a clear protocol between GAP and forensic services that evidences robust communication, along with recorded evidence of discussed and agreed clinical decision making for all patients.

The forensic psychologist told us that they are involved in developing the risk formulation plans of forensic patients in the IPCU, and continue to provide in-house training to all qualified nursing staff. This had consisted of RAID (Reinforce Appropriate, Implode Disruptive) and trauma-informed care training. RAID is a positive focused, least restrictive approach for working with patients who exhibit challenging behaviour. There are plans to deliver the trauma-informed training to the health care support workers.

Recommendation 2:
Managers must ensure that all patients in the IPCU have equitable access to psychological therapies.

Use of mental health and incapacity legislation

Four out of the five patients in the ward were subject to detention either under the Mental Health Act or Criminal Procedures (Scotland) Act 1995 (CPSA), and we found that the paperwork was in order.

Part 16 (s235-248) of 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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were all in place.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we would expect to find copies of this in the patient's file, and we saw examples where a patient had nominated a named person.

When we are reviewing patient files we looked for copies of advanced statements. The term 'advanced statement' refers to written statements made under ss274 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. Where it was recorded that a patient did not have one in place, we suggested that it was important to have a follow-up discussion during the patient's journey, as a patient may not be capable on admission to make an advanced statement, however this may change.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act (AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the AWI Act. We saw that where appropriate, the patient had a completed s47 certificate, along with treatment plan.

Rights and restrictions

We wanted to follow up on our recommendation in relation to specified persons. Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on patients who are detained in hospital. Where a patient is a specified person in relation to these sections, and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would expect restrictions to be legally authorised and that the need for specific restrictions regularly reviewed, along with reasoned opinions to be documented in the files. We found that where a patient had been made a specified person that all paperwork, including reasoned opinion was in order.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

The IPCU is a locked ward and we were aware that one patient was admitted to the ward on an informal basis. The patient told us that since their admission they were only allowed out of the ward at certain times, and had raised concerns about this, as this was not their understanding of what an informal admission meant. We are concerned when there is an admission of an informal patient to an IPCU, and note that this is unusual, so we followed this up with the forensic consultant on the day of our visit. We were told that the patient had been admitted the previous evening and was admitted to the IPCU rather than GAP ward due to bed capacity, however the situation would be kept under review.

The ward has good links with the local advocacy service who are based in the Royal Cornhill Hospital.

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

Activity and occupation

The Blair unit has an activity nurse who provides input across the three wards. We were told that the unit has recently recruited another activity nurse and the service has plans to enhance the delivery of therapeutic provision to patients. We felt this addition was positive and welcomed the focus on the importance of activities as part of the patient's recovery. We look forward to hearing about this on our next visit.

Patients were able to tell us about activities they enjoy and participate in. We saw evidence in patient's notes of one-to-one activities that were happening, in and out with the ward, and how activities benefit the patient.

We heard there has been limited OT input to the ward for some time, with this provision only being for forensic patients. However, we were told of a patient where special provision had been made as the patient required this. We heard of the ongoing challenges in recruiting OTs across the service, and that there has been a recent appointment of a lead OT to review current provision in all in-patient settings.

Recommendation 3:
Managers must ensure that all patients in the IPCU have equitable access to occupational therapy.

The physical environment

We wanted to follow up on the recommendations we made in relation to accommodation following our last visit. Although the recommendation was made for units across the Blair unit, we only viewed the IPCU on this visit.

We were concerned to see that no works in relation to the accommodation have been carried out. There continued to be shared dormitories in place, male and female patients continue to share bathrooms, there were various ligature points in the rooms, and black mould in bathrooms.

The Commission is aware that the Minister for Mental Wellbeing and Social Care visited the Blair unit in May 2022 and also raised concerns with the health board regarding the condition of the current accommodation. Since our last visit, managers told us that bed numbers have been reduced in the IPCU, to try and prevent patients from sharing living accommodation, however on the day of our visit, patients were still sharing. We were told that some walls had been painted, however it was difficult to see this as each room was very stark, unwelcoming and bleak. Large boards of wood has been put on some walls in rooms, to cover the holes.

Patients, the relative and staff told us about the impact of the environment on delivering safe patient care, particularly with a significant number of ligature points, with unsuitable furniture and windows that are sealed, restricting fresh air into the ward.

The ward has access to an enclosed garden and patients told us that they enjoyed this access, particularly as some patients can be restricted to the ward.

The Independent Review into the Delivery of Forensic Mental Health Services, 2021 made recommendations regarding the physical environment of forensic services and that health boards required to address these issues. The Commission has previously made recommendations prior to the visit in October 2021, and continues to be concerned regarding the lack of progress made.

Managers told us that there have been ongoing meetings to discuss the environmental issues and how these issues can be addressed, in the short, medium and longer term. We would like to know what action is being taken to address these significant issues and will therefore write to the managers of NHS Grampian.

Recommendation 4:
Managers must address the deficits in the physical environment and formulate a robust action plan to ensure the accommodation promotes patient safety, whilst protecting privacy and dignity.

Summary of recommendations

Recommendation 1:
Managers must develop a clear protocol between GAP and forensic services that evidences robust communication, along with recorded evidence of discussed and agreed clinical decision making for all patients.

Recommendation 2:
Managers must ensure that all patients in the IPCU have equitable access to psychological therapies.

Recommendation 3:
Managers must ensure that all patients in the IPCU have equitable access to occupational therapy.

Recommendation 4:
Managers must address the deficits in the physical environment and formulate a robust action plan to ensure the accommodation promotes patient safety, whilst protecting privacy and dignity.

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.

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 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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