Mental Welfare Commission for Scotland

Report on announced visit to:

Forensic Acute and Forensic Rehabilitation Wards, Blair Unit, Royal Cornhill Hospital, Cornhill Road Aberdeen, AB25 2ZH

Date of visit: 27 October 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 on this occasion, we visited the forensic acute ward and forensic rehabilitation wards. A visit was undertaken to the IPCU in September 2022.

The forensic acute ward is defined as a low-secure, acute forensic psychiatry ward for male patients; it has eight beds. The forensic rehabilitation ward is a low secure forensic psychiatry in-patient rehabilitation unit for male patients with 16 beds. The forensic acute ward was full on the day of our visit, and the rehabilitation ward had 15 patients. Patients are transferred to the rehabilitation ward from the acute ward, once their mental health has stabilised and are able to participate in the next stage of their recovery.

On the day of this visit we wanted to speak with patients, relatives and staff. We also wanted to find out how the ward had implemented the recommendations from the last visit in October 2021. Recommendations from our previous visit related to treatment certificates, patient involvement and participation, specified person legislation and accommodation.

Who we met with

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

On the day of the visit we spoke with the acting SCN’s, nursing staff, CNM, consultant psychiatrists and service manager. Contact was also made with the local advocacy service and clinical psychologist.

We met with 10 patients and reviewed the case notes of six patients.

Commission visitors

Tracey Ferguson, social work officer

Lesley Paterson, senior manager (practitioners)

Graham Morgan, engagement and participation officer

What people told us and what we found

Care, treatment, support and participation

The SCNs told us that patients were at various stages in their recovery journey, with some patients spending longer periods in hospital, and others having a more recent admission or they had been recently transferred to the rehabilitation ward. Patients in the acute ward required more intensive assessment and support due to their mental ill health. Patients in the rehabilitation ward were actively working on their rehabilitation plans, regaining independent skills and were often out and about in the community. Some patients were actively planning for discharge and we heard about the plans that were in place for patients who were moving onto the next stage of their recovery.

Feedback from the patients was variable across the wards. Patients in the rehabilitation ward told us that the peer support on the ward was good and really valuable. Some patients described staff as caring, helpful and approachable. One patient told us that there was good leadership in the ward between the doctors and nurses and how they really helped with discharge planning. We heard from some patients that there was an emphasis on the rules and regulations of the ward, whilst others told us that the doctors did not listen. Some patients were able to tell us about their treatment, care planning and their participation at meetings, meaning that they felt involved in their care and treatment.

Of patients that we spoke with in the acute ward, told us that they had a good rapport with the staff. Some patients told us that they disagreed with their hospital admission, were unhappy with their treatment and were unsure of their rights. Most patients told us that they should be allowed to vape or smoke in the garden, as they found it difficult to get off the ward. One patient told us that there was a lack of space for visitors and no privacy. Patients described feeling bored with not much to do on the ward.

The wards continued to have a member of staff assigned to be present in the communal area at all times. They were identified as the 'immediate responder' and were available to respond to any incidents that may occur in the day room, corridors, garden or games room.

We heard from managers about the ongoing staffing challenges in trying to fill vacant posts and we recognise that the recruitment of nurses is an issue nationally. Since our last visit we were told about changes to the leadership team and how both wards currently have temporary staff in the position of senior charge nurse. The acting SCNs told us about continued proactive efforts to recruit staff to vacant posts, and more recently had managed to recruit three nursing graduates into vacancies across the Blair Unit. We were told that staff work across the Blair unit, depending on clinical demand in each ward, which was reviewed at the managers daily huddle meeting. Staff told us that this model of working provided them with the opportunity to work with patients who were at different stages of their journey.

Nursing care plans

We saw evidence of detailed care plans, with regular reviews taking place however, these were variable in the files we reviewed. Whilst some care plans were person-centred others appeared generic and lacked specific detail. Some records had summative evaluations of the care plan reviews, but this was not consistent, therefore it was difficult to know where the changes to

the plans had been made or if the interventions in the care plans were still effective in supporting patients to achieve their goals. We would expect that summative evaluation and review of individual care plans, including any changes that were made, to be clearly documented in the care plan, and in the notes. We discussed one care plan with the SCN where it had been recorded that the patient had a financial guardianship in place, which was inaccurate.

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; some had signed their care plans and others had recorded that the patient refused. We were pleased to see that where a patient's first language was not English, there were documents about their care, treatment and their rights that had been translated to a format that patients understood.

We emphasised the importance of staff continuing to review patient's participation in the care planning process, throughout various stages of their journey and about the use of other technology/devices to support patients whose first language was not English.

We were concerned that there had not been a consistent improvement across the nursing documentation, given we were told that this would be addressed with the audits that were being undertaken. We were aware that there had been changes to the leadership team since our last visit, and this is likely to continue given that the SCN's are in acting positions. This change was likely to have an impact on the audit programme, and the improvements that needed to be made; our concern is that this may continue until permanent SCNs are in position.

Recommendation 1:
Managers should review their audit processes that are currently in place in order to improve the quality of care plans and ensure that evaluations of care plans clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals, evidencing patient participation.

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)

We were told that the MDT meeting continued to take place weekly and the MDT consists of three consultant psychiatrists, nursing staff, occupational therapy (OT), a forensic clinical psychologist, as well as input from pharmacy. We were told that the provision of OT to the wards had been reduced recently, and heard of the ongoing efforts to try and recruit to vacant OT posts. We were aware that there was a review of OT provision across all wards and we will continue to link in with senior managers about the outcome of the review.

The forensic psychologist told us that they were involved in developing the risk formulation plans for all forensic patients and continued to provide in-house training to all qualified nursing staff. This had consisted of RAID (Reinforce Appropriate, Implode Disruptive) and training in

trauma-informed care. RAID is a positive focused, least restrictive approach for working with patients who exhibit challenging behaviour. There were plans to deliver the trauma-informed training to the health care support workers. The forensic service had two psychologists that provided input to patients care and treatment, however we were told that one of the psychologists had recently left post and the service was actively recruiting for a replacement.

All allied health professional (AHP) records were kept separately, and where assessments had been undertaken, copies of these were kept in the patients notes on the ward. All care notes continued to be in paper files, and we were aware that NHS Grampian were looking to implement an electronic recording system at some point in the future, but no date has been identified as yet.

In the MDT record we saw that there was a recorded entry of who attended, a detailed update for the meeting, along with outcomes and actions from the meeting. We were told that patients do not attend this meeting however the consultant will meet with the patient before or after the meeting and the patient can discuss any issues for this meeting with the nursing staff.

We found detailed nursing assessments that were completed on admission, and updated appropriately. Risk assessment and risk management plans were also in each patient's file, and highlighted relevant risk areas, along with evidence of ongoing review.

Several patients were subject to Multi Agency Public Protection Arrangements (MAPPA) and also to the Care Programme Approach (CPA). CPA is a framework used to plan and co-ordinate mental health care and treatment, with a particular focus on planning the provision of care and treatment by involvement of a range of different people and by keeping the individual and their recovery at the centre. We were told that these meetings were held on a six-monthly basis and were clearly recorded, with timely outputs covering all key areas. We were pleased to see evidence of patient participation at these meetings. The care plans and risk assessments as part of the CPA documentation were detailed. We had a further discussion with managers on the day, advising them that this level of detail should be incorporated into the individual care plans for each patient. We found that not all information in the CPA minutes was as up-to-date and as accurate as it should be. For example, it was recorded in a patient's most recent CPA minute that the last discussion the patient had with their RMO about their advance statement was in 2020. The RMO and staff told us there had been more recent discussions and we saw evidence of this in the file. We found in another CPA minute that it had been recorded that a patient last had an ECG in 2020, but the RMO told us that patients have these tests regularly when attending the clozapine clinic. We had further discussions on the day with staff and RMO's about the importance of accurate recording and reviewing information in the CPA meetings.

We wanted to follow up on our last recommendation about the reporting of delayed discharges. Scottish Government has set out guidance about the reporting of patients who are identified as delayed discharges in hospital settings, and we would expect that where this occurs, health boards record this accordingly. The SCN's told us that these discussions took place during the patients CPA meeting or case review meetings. On the day of the visit, we were told that two patients had been recorded as delayed discharge and heard about the

active planning that was happening. We also heard of discharge plans for other patients and we followed up on one patient where the recording in the case review was lacking in detail.

Use of mental health and incapacity legislation

All patients across the two wards were detained under the Mental Health (Care & Treatment) (Scotland) Act 2003 (Mental Health Act) or Criminal Procedure (Scotland) Act 1995. In the files we reviewed, we found that all detention paperwork was in good order.

We wanted to follow up on our recommendation from last year's visit about Mental Health Act treatment certificates. 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. We reviewed all of the relevant treatment certificates, along with medication prescription kardex.

We found several issues with the treatment certificates (T2 and T3) that had been completed by the responsible medical officer (RMO) to authorise treatment under the Mental Health Act. Treatment certificates should be reviewed as part of the weekly MDT process, along with input from pharmacy staff, 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.

We were concerned about this lack of improvement, and the impact on patient's rights, given that some patients were receiving treatment out with the authority of the Mental Health Act.

We were told that the ward continued to have input from pharmacy, and that any discrepancies would be picked up during audit checks, or during weekly medication orders, whilst staff are checking patients T2/T3 against prescriptions. The audits systems and checks that we were told were in place were not working and therefore as this previous recommendation has not been met we will escalate this to senior managers within NHS Grampian.

Recommendation 2:
Managers and medical staff should ensure that all forms that record treatment are current, legally authorise all treatment, are discussed and reviewed at the weekly MDT meetings and that a robust audit system is introduced to ensure compliance.

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. We saw examples where a patient had nominated a named person and this was recorded in the CPA documentation.

When we are reviewing patient files we looked for copies of advance statements. The term 'advance statement' refers to written statements made under s274 and 276 of the Mental Health Act, and is written when a person has capacity to make decisions on the treatments they do or do not want. Health boards have a responsibility for promoting advance statements. We saw that some patients had made an advance statement and where it was recorded that a patient did not have one in place, we suggested that it was important to have follow-up

discussions throughout the patient's journey, such as in the CPA meetings or during one-to-one meetings, along with support from advocacy.

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, where appropriate, s47 certificates, along with accompanying treatment plans. We discussed one patient's s47 certificate on the day, as it was confusing. It had recorded that the patient needed the certificate for medical treatment due to mental illness, as decision making ability was impaired. However, the patient had a T2 in place, consenting to his treatment under part 16 of the Mental Health Act. The RMO agreed to follow this up with the medical practitioner who completed the s47 certificate.

Rights and restrictions

We wanted to follow up on our recommendation in relation to specified persons. S281 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 is regularly reviewed, along with reasoned opinions to be documented in the files.

We were aware that in some areas, admission to a low secure (forensic) ward results in almost automatic designation as a specified person. We do not think this practice is compatible with the principles of the Act, nor with each individual's human rights. All low secure facilities, IPCUs and acute admission wards should therefore, make decisions about specifying people and implementing these regulations on an individual basis and only when the RMO has recorded a reasoned opinion that sets out the risk to the patient, or to others, if these restrictions were not put in place.

All patients in both wards had been made a specified person. We discussed this further with nursing staff and RMO's who told us that each patient was individually assessed and this was not automatic practice across the wards. From the files we reviewed, we found that where a patient had been made a specified person that all paperwork, including reasoned opinion was in order. We did however raise one case with senior managers as the reason given for the specified person status related to the type of ward the patient was in, and not the individual risk of the patient, or others. We were told that this would be reviewed.

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

The ward had good links with the local advocacy service who were based in the Royal Cornhill Hospital, and we saw evidence of patients meeting with their advocate, as well as them being supported during 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

Activity and occupation

The Blair unit had an activity nurse who provided input across the three wards. We were told that the unit had recently recruited another activity nurse and the service had plans to enhance the delivery of therapeutic provision to patients. We felt this additional role 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 that they enjoyed and participated in. We spoke to the OT assistant on the day of our visit about activities across the wards. We were told that activities happen either in groups or on an individual basis, depending on the patient's stage of their recovery. We heard about the links that had been made with community facilities and some patients told us about these and of the benefit to them.

Although there was a recovery resource centre situated in the hospital, we were told that the OTs mainly use the kitchen facilities in the unit, for rehabilitation purposes. We saw this on the day of the visit and patients told us that enjoyed learning new skills, such as cooking and baking. We were told that OTs continued to be involved in developing weekly ward-based activities with staff and patients and in planning off-ward activities. We were told that the provision of OT to the wards had reduced due to the vacant posts, however we still saw activities happening and recorded in patient notes.

In the acute ward, patients had access to a games room with a pool table, games console and TV & DVD player. There was a separate activities room in the rehabilitation ward where there were displays of patients art work and where some patients told us they played musical instruments. Unfortunately, the snooker table in the rehabilitation ward had been damaged and patients told us that they missed this activity, as they enjoyed playing snooker. The SCN told us that this was to be repaired but can often take time.

We previously heard about a joint initiative with Aberdeen HSCP where the unit had an adult learning tutor allocated for 12 hours per week offering learning opportunities for patients who could not access resources in the community, due to restrictions or offending behaviour. However we were told that this post had recently been vacated and will seek an update from senior managers.

The SCN told us about the wards applying for the use of a lease car to support patients accessing community resources, and were awaiting approval.

The physical environment

We wanted to follow up on the recommendations we made in relation to accommodation following our last visit. On this visit, we reviewed the accommodation across both wards as we had with the IPCU in our earlier visit in September.

Accommodation in both wards consisted of single rooms and dormitories. Some patients told us that they did not like the shared dormitory as it can often be untidy and noisy. A wet room had now been installed in one of the dormitories in the rehabilitation ward and a patient told us that this was great. We were told of works that continued to be on the risk register and other areas where some work has been partly completed, however there still continued to be various ligature points, and black mould on seals in bathrooms, along with flooring that needed replaced.

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

There were staff rooms in the acute ward and the rehabilitation ward, however there was a lack of interview space across both wards.

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.

Patients and staff told us about the impact of the environment on delivering safe patient care, particularly with significant ligature points, unsuitable furniture and windows that were sealed, not allowing fresh air into 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 had 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 had been ongoing meetings to discuss the environmental issues, across the whole unit and across the forensic pathway in NHS Grampian. Discussions are taking place as to how these issues could 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 3:
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 should review their audit processes that are currently in place in order to improve the quality of care plans and ensure that evaluations of care plans clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals, evidencing patient participation.

Recommendation 2:

Managers and medical staff should ensure that all forms that record treatment are current, legally authorise all treatment, are discussed and reviewed at the weekly MDT meetings and that a robust audit system is introduced to ensure compliance.

Recommendation 3:

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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