Mental Welfare Commission for Scotland

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

Date of visit: 21 September 2023

Where we visited

We carried out an unannounced visit to the intensive psychiatric care unit (IPCU), which is based in the Blair Unit in the main Royal Cornhill Hospital. The Blair Unit is compromised of the IPCU, a low secure forensic acute ward, and a forensic rehabilitation ward.

As part of our visiting programme, we visit the IPCU separately. The IPCU does not only admit patients who are managed by forensic services, but also patients known to the general adult psychiatric (GAP) services.

The IPCU is a locked unit and provides intensive treatment and interventions to individuals that present with an increased clinical risk and who require a higher level of observation. Individuals can either be admitted from the courts due to criminal offending behaviour, may be transferred from prison due to mental ill health or admitted following a referral from a GAP consultant. Where a clinical need has been identified following a referral from a GAP consultant, the Blair Unit forensic consultant psychiatrist, who was responsible for admissions and referrals on that specific day would determine if the criteria for admission to the IPCU was met. We were told that there was an IPCU patients' pathway in place that was being reviewed.

The IPCU was an eight-bedded mixed-sex unit, and on the day of this visit, there were eight individuals in the ward. We were told that the eight individuals were identified as 'forensic patients' and that three of those individuals were boarding in the IPCU from the other two forensic wards in the Blair Unit. There were no individuals in the ward from GAP services on the day of the visit.

Managers told us on our previous visit that there had been a decision to reduce the bed capacity to six, due to the issues identified in the accommodation from our previous visits. However we were told that due to the demand, the ward had never managed to achieve this reduction in capacity.

On the day of this visit we wanted to speak with individuals, relatives and staff. We also wanted to find out how the ward was implementing the recommendations from the last visit in September 2022. Previous recommendations were regarding access to occupational therapy (OT) and psychology services, accommodation and protocol between GAP and forensic services.

Who we met with

When we plan a visit, prior notice is given to individuals and relatives of our intention to visit. Given that this visit was unannounced, we were unsure if we would have the opportunity to speak with individuals and relatives, however we managed to speak with four individuals and we also reviewed the care and treatment of three of those individuals and one other.

We spoke with the senior charge nurse (SCN) nursing staff, the clinical nurse manager and consultant psychiatrists.

Commission visitors

Tracey Ferguson, social work officer

Dr Arun Chopra, medical director

What people told us and what we found

Care, treatment, support and participation

Throughout the day of our visit, we introduced ourselves to the individuals in the unit. We had been told that some individuals had recently been admitted to the unit, whilst others had been in the unit for a longer period. From those that we spoke with, feedback about staff was mostly positive, and patients described staff as 'supportive', 'caring' and 'lovely'. Individuals told us that they enjoyed the one-to-one time with staff and we heard about the time they were able to spend off the ward.

Some individuals told us that they were unhappy being in hospital whilst others told us about restrictions that were in place and that they were not happy about, such as a lack of access to their mobile telephone. One individual told us that they wanted more time off the ward and another individual expressed their dissatisfaction about a nurse standing outside their door at all times. All individuals we spoke with were unhappy about the accommodation and described it as 'poor', 'awful' and 'not therapeutic'. One person told us about having to share a dormitory with another person and how there was only a curtain between them, offering no privacy whatsoever. The same person told us that the information about a previous patient was still on the chalk board above their bed space, which we were able to see.

Some individuals were able to tell us about their care and treatment and of the regular discussions that they had with their consultant psychiatrist. We heard about the activities that were available and how individuals enjoyed these, and how spending time with the activity coordinator and occupational therapist (OT) aided their recovery.

Managers told us how they had continued to have a daily huddle to discuss bed pressures, patients' admissions and discharges, along with staffing numbers, to ensure safe delivery of patients' care across the Blair Unit. This information is then fed into the hospital wide huddle where the same issues are discussed for the whole hospital.

Patients in the IPCU required intensive support and treatment to assist their recovery during the most acute phase of their mental ill health, and due to the lower number of individuals in an IPCU, along with a higher staff ratio, staff felt that they had the time to deliver this in a person-centred way. From speaking to the staff team, we got a sense that they knew the patients in the unit well. We were told that staff were required to work across the Blair Unit, depending on clinical demand in each ward. Some of the staff team we spoke with told us that this was helpful as it enabled them to work with patients throughout their recovery journey, and it also provided them with increased clinical experience. However, we are aware that the other two wards in the Blair Unit are solely for forensic male patients and were told that the females in the IPCU who had ongoing forensic needs, tended to be discharged from the unit, as there was no forensic pathway for females.

The SCN told us about continued proactive efforts to recruit staff to vacancies and it was positive to hear that there was only one band 3 vacancy in the ward.

Nursing care plans

In the clinical records we saw regular evidence of one-to-one sessions between individuals and staff that were very detailed, that provided a progress update about the care and

treatment of the individual, along with incorporating discussions about individual views and wishes into the sessions. The level of detail was comprehensive and what we would expect to see in an IPCU.

The standard of the care plans, and the level of detail in them was variable. Whilst some were reasonably detailed and person-centred, others were lacking in this, many were not signed or dated by nursing staff and were unclear with regards to individual participation. We found some care plans that had no regular reviews and no evaluations, making it difficult to determine if the current care plan was effective. Managers told us that there was a working group across the Royal Cornhill Site that was looking at care planning documentation and processes and that the SCN from the IPCU was leading on this. We were pleased to hear about this development, as we had made previous recommendations on this area during earlier visits and care planning has continued to be a recurrent theme on some of the more recent visits across Grampian; we will write to managers to request an update.

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

Recommendation 1:
Managers should ensure that there is a regular audit process in place in order to improve the quality of care plans and ensure that they reflect and detail interventions which support each patient's movement towards their care goals, along with regular reviews, summative evaluations, and evidence of individual and carer involvement.

Multidisciplinary team (MDT)

There are three forensic consultant psychiatrists who cover the Blair Unit and who have responsibility in determining the admissions to the IPCU. For individuals who were admitted to the IPCU and did not have a forensic background, we were told that an adult mental health psychiatrist would be appointed as the individual's responsible medical officer (RMO). Where a person was detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) a GAP consultant would continue to be responsible for reviewing the care and treatment.

We wanted to follow up on our last recommendation in relation to the service developing a clear protocol between GAP and forensic services. The SCN and consultant psychiatrists told us that there had not been a new protocol developed however, the current IPCU patient pathway documentation was being reviewed. We reviewed one care file where the individual was known to forensic services, however, following admission to the GAP ward, due to no available beds in the IPCU, we saw that the forensic RMO had regularly reviewed the patient in the ward they were boarding to.

We wanted to find out about the input from GAP services to the unit. Given the IPCU is not a forensic unit, although it is based in the Blair Unit, we were aware that the forensic consultants would decide on admissions. The SCN told us that they linked in with the adult services daily at huddles or prior to decisions being made to move patients between security levels when beds are available; however, they have found that there were not many referrals being made

to the IPCU and were unsure of the reasoning behind this. We heard how there was a clinicians meeting each week to review individuals across the Blair Unit, however we were told that there was no involvement or input from GAP services at this meeting. There is however a meeting every few months between GAP and forensic services.

We were told that the MDT meetings continued to take place weekly and the MDT consisted of consultant psychiatrists, nursing staff, OT and forensic clinical psychologist. We wanted to find out if all individuals had access to OT and psychology, as we had identified from our previous visit that these services were not accessible to all individuals. We linked in with OT leads who informed us that there were OT vacancies across all services however, the service had been reviewing the provision across all wards to ensure OT provision was accessible for all. Ward staff and the SCN told us that all individuals, where it had been identified, had access to OT, and that staff and patients valued this service.

The SCN told us that the forensic psychologist continued to be involved in developing the risk formulation plans of forensic patients in the IPCU and psychological interventions; and they continued to provide in-house training to the staff, which they greatly benefitted from. We heard that access to psychology for all individuals has not yet been addressed. We are aware that GAP services now have psychology provision and that there have been ongoing discussions with senior managers about how to address the lack of access for all individuals. We were told that senior managers were looking to allocate funding to secure an additional psychology post to address this. We will ask senior managers to provide us with an update regarding this.

In the MDT meeting record we saw that there was a recorded entry of who attended the meeting, however, this was not always completed. We were aware from an action following a significant adverse review in Grampian that one of the recommendations and actions was to ensure that full names of who attended the MDT meeting were recorded on the MDT meeting record. It was therefore concerning that such actions plans were being developed from adverse incident reviews although were not yet being put into practice.

We were told that patients did not attend the weekly MDT meeting however, the consultant would meet with the patient before, or after the meeting and the patient could discuss any issues from this meeting with the nursing staff.

The MDT documents that we viewed provided a detailed update by nursing staff to present at the meeting. Although patients told us that they did not attend the meeting, they also told us that they were able to put forward requests. We saw this section on the document, however it was not always completed and was difficult to know who was responsible for feeding back to the patient from the meeting.

Recommendation 2:
Managers should review and promote the accessibility of the IPCU resource to GAP services.

Recommendation 3:
Managers must address the inequitable access psychological therapies for patients in the IPCU, ensuring that GAP patients are afforded the same access as patients managed by forensic services.

Care records

Care records were in paper format, and each nursing and medical file was organised with separated sections for information. We found in one individual's file that all the daily nursing notes were not together and there were entries missing from the date of admission. We were told that the individual was admitted to an acute adult mental health ward, then was boarded out to a learning disability ward, before transferred to IPCU. We were told that each ward would keep their own entries, however we found this concerning as there was some paperwork from other wards, but clearly not all.

We continue to hear about the plans for NHS Grampian to move to a new electronic system in the near future. We were told that there were ongoing pilot sites testing the system, in the hospital, however as yet, there is no planned date for this to be rolled out to all services. This will be an opportunity for records to become integrated, as there are some aspects of current record management that were disjointed, which can increase clinical risk. We suggested to managers that they need to ensure that the new electronic system will fully meet their needs and lend itself to robust and detailed recording for all MDT professionals.

Use of mental health and incapacity legislation

On the day of the visit eight individuals were subject to detention either under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'), or detained under the Criminal Procedures (Scotland) Act 1995 (CPSA); we found that the detention paperwork for the files we reviewed was in order.

Part 16 (sections 235 to 248) of the Mental Health Act sets out the conditions under which treatment may be given to persons 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 all in place.

When we are reviewing patients' files we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 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 were told that one of the patients had an advance statement in place, however we could not find a copy in the current nursing or medical records; we brought it to the manager's attention.

Rights and restrictions

The IPCU continued to operate a locked door commensurate with the level of risk identified in the patients group; there was a locked door policy in place.

The SCN told us that there were five individuals in the unit that were on continuous interventions, and that the reasons for this was due to the current environmental factors, because of the accommodation, and/or due to the mix of complex patients in the ward. We would expect ongoing, regular reviews to take place for anyone who was subject to continuous interventions and found this to be the case. However we had concerns regarding the necessity of such restrictions and how the environment has an impact on these decisions.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on individuals who are detained in hospital. From reviewing the patients' information on the unit whiteboard, it was recorded that all patients had been made a specified person, under safety and security measures of the Mental Health Act. When we reviewed the care records, we could not find the legal documentation that authorised such measures. We spoke with the nursing staff and a psychiatrist and found that there was confusion and lack of clarity with regards to what restrictions were in place for each person. We met with one individual who told us that they had been made a specified person, and we saw that this had been recorded in their care plan however, we could not find any paperwork in the file. We found another care plan where an individual's access to their mobile telephone had been restricted and the reasons for this, however there was no legal authority in place to authorise such restrictions.

Individuals told us that they were unhappy about their mobile telephones being removed and when we spoke with staff, they told us that all patient's phones were removed when they were admitted to the ward, under to the unit's policy. We asked for more detail about this and were told that NHS Grampian had implemented a blanket restriction policy, which covered the removal of mobile telephones and other such items.

The Commission was aware that NHS Grampian had to devise a blanket restriction policy, following a legal requirement by the health and safety executive and the Commission provided advice and a view with regards to the policy. However in accordance with the policy we did not find individual risk assessments in place for such restrictions or the appropriate legal authority. It was unclear if individuals were consenting to having their telephones removed, as well as having restricted access, as there was no recorded discussion in any of the files we reviewed. We looked at care plans where it had been documented that the restriction of access to a mobile telephone was in place in order to restrict calls however, there was no specified person paperwork in the file. We were concerned about the level of restrictions in place that were not authorised, and the lack of clarity between ward nursing staff and psychiatrists.

The Commission had made a recommendation with regards to specified person following a visit to the Blair Unit in 2021, therefore it was concerning to hear that restrictions had been placed on individuals without proper legal authorisation in place. It would appear that the implementation of the blanket restriction policy may have confused matters, which was also concerning. We found in some patients' files that they were subject to restrictions, as it had been recorded that the individual was in low secure environment. The IPCU is not a low secure environment, and even if the person was in a low secure environment, they would not automatically subject to specified person legislation. We discussed this with the SCN and managers on the day and requested that any current restrictions be reviewed as a matter of urgency.

Recommendation 4:
Managers should ensure that where restrictions are placed upon an individual, these should be proportionate, reasonable and justifiable, ensuring appropriate legal frameworks are in place to authorise such measures under the Mental Health Act, where required. Each individual case should be risk assessed, with a clear risk management plan in place,

incorporating reviews into the plan, and individuals should not be subject to restrictions for any longer than necessary.

Recommendation 5:
Managers should provide specified person legislation training to all staff working in the IPCU to ensure there is a shared working knowledge of all aspects of this legislation and the need for measures to be authorised, reviewed and the completion of reasoned opinions, setting out the rationale for enacting these measures.

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

Activity and occupation

The Blair Unit had two activity nurses that provided input across the three wards, which included the IPCU. We continued to hear how this role enhanced the delivery of therapeutic provision to individuals. The ward also had access to OT provision and individuals were able to tell us of the activities that they participated in, on and off the ward, and of the benefit to them. We found evidence of this in the individual files that we reviewed along with the link to the individual's care goals. Those that we spoke with told us about their different experiences including the support from OT to help find a voluntary job in the community, drawing, watching DVD's and listening to music.

The physical environment

We wanted to follow up on the previous recommendations that we have made in relation to the accommodation, following our last three visits. We were aware following our last visit that discussions had taken place with senior managers and Blair Unit staff, to improve the accommodation across the whole Blair Unit in the short, medium and long term to patients' care.

Since our last visit, we were extremely concerned to see that there have been no improvements to the accommodation in the IPCU. During our last visit we were told that partitions were due to be fitted in the dormitories in October 2022, which would have provided a level of privacy for individuals, however this work had not been undertaken. At that time, the SCN and consultant psychiatrists told us that there had been ongoing meetings to look at what was needed for patients' care in the future in the Blair Unit and IPCU, and we had a sense of a real momentum for change. However, on this visit, we were told that there had been no progress and that the momentum had stopped.

The dormitories and individual rooms were bleak, and in desperate need of paint, as was the whole unit. The shared dormitories only had a curtain between individual's bed spaces that offered no privacy or dignity and there were various ligature points identified across the unit. The rooms were exactly the same as last year, with large blocks of wood fitted on some parts of the wall to hide the holes. The unit only had one communal area which was this same area where individuals ate their meals, watched television, carried out activities and played pool. Males and females had to continue to share bathrooms, with black mould, which was evident on our last visits. There continued to be leaks from one bathroom that was impacting on one of the single bedrooms. Staff again told us about the impact of the environment on delivering

safe care to patients, particularly with significant ligature points, unsuitable furniture and windows that were sealed, preventing fresh air into the ward. We were told of recent incident where a patient had pulled the metal parts from the ceiling air vents to use as a weapon, which placed staff and other patients at risk; although this was in forensic acute, the same vents are in use in the IPCU.

Our view was that individuals who required to be admitted to an IPCU should not have to share a dormitory and should have their care, treatment and support provided in a welcoming and therapeutic environment.

The Independent Review into the Delivery of Forensic Mental Health Services that was published in February 2021 made recommendations regarding the physical environment of forensic services and that Health boards required to address these issues.

We continue to be significantly concerned about the accommodation in the unit, as was the Minister for Mental Wellbeing and Social Care, who visited the Blair Unit in May 2022, however nothing has changed. As the minister raised concerns with the health board regarding the state of the accommodation, we are unsure if the Minister has followed this matter up with the health board and therefore we will write to Scottish Government and the health board for clarification. We are also repeating our recommendation from our last visit.

Recommendation 6:
Managers must address the significant deficits in the physical environment and formulate a robust action plan to ensure the accommodation promotes patients' safety, whilst protecting privacy and dignity.

Summary of recommendations

Recommendation 1:
Managers should ensure that there is a regular audit process in place in order to improve the quality of care plans and ensure that they reflect and detail interventions which support each patient's movement towards their care goals, along with regular reviews, summative evaluations, and evidence of individual and carer involvement.

Recommendation 2:
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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.

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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