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: 22 November 2023

Where we visited

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.

On this occasion, we visited the forensic acute and forensic rehabilitation wards. A visit was undertaken to the IPCU in September 2023.

The forensic acute ward is defined as a low secure acute forensic psychiatry ward for male individuals and has eight beds. The forensic rehabilitation ward is a low secure forensic psychiatric inpatient rehabilitation unit for male individuals, with 16 beds. The forensic acute ward was full on the day of our visit, and the rehabilitation ward had 17 individuals. We were told that the ward uses two 'surge beds'; these are used at times of high demand. We were told that individuals were transferred to the rehabilitation ward from the acute ward once their mental health had stabilised, and when they were able to participate in the next stage of their recovery.

On the day of this visit, we wanted to speak with individuals, relatives, and staff. We also wanted to find out how the ward had actioned the recommendations from the last visit in October 2022. Previous recommendations were made with regards to Mental Health (Care & Treatment) (Scotland) Act 2003 (Mental Health Act) treatment forms, individuals' involvement and participation in their care and treatment, and the physical environment.

Who we met with

Prior to the visit, we held a virtual meeting with both senior charge nurses (SCNs), the clinical nurse manager (CNM), and the forensic consultant psychiatrists.

On the day of the visit, we spoke with the SCNs, ward staff, the occupational therapist (OT) and the consultant psychiatrists. Contact was also made with local advocacy service.

We met with nine individuals, reviewed the care notes of eight, and spoke with one relative.

Commission visitors

Tracey Ferguson, social work officer

Lesley Paterson, senior manager (practitioners)

Graham Morgan, engagement and participation officer

Anne Buchanan, nursing officer

What people told us and what we found

Care, treatment, support and participation

Since our last visit, we were pleased to hear that both senior charge nurses (SCNs) for the two wards were now in permanent positions. We were told that staff can work across the Blair Unit, depending on the clinical demands of each ward, which are reviewed at the manager's daily huddle meeting. Staff told us that this model of working provided them with the opportunity and experience to work with individuals, throughout different stages of their journey, across the whole service.

Managers told us about the recruitment drive to fill vacant posts, and of the nine newly qualified nursing graduates that have recently been recruited to work in the Blair Unit. We were told that the retention of staff has been challenging however, we heard that where staff had left posts, most had moved to other posts in the forensic service, which was positive. We were told of a new post that had been developed in the forensic outreach team and of the benefits of the post in linking in with the wards, GP practices and community teams.

The SCNs told us that individuals were at various stages in their recovery journey, with some spending longer periods in hospital, and others who have had a more recent admission or transfer between the forensic services.

Individuals in the acute ward required more intensive assessment and support due to the acute phase of their mental health, whereas individuals in the rehabilitation ward were actively working on their rehabilitation plans, regaining independent skills and were more engaged in community activities. We were told that some individuals were actively planning for discharge and we heard about plans that were in place to support people moving onto the next stage of their recovery.

Feedback from the individuals varied across the wards. Some individuals described the staff in the forensic acute ward as "great", and "friendly", and that "they do an amazing job but are underpaid, undervalued and under resourced". Others told us that staff do as much as they can, will often come and speak to individuals and provided the support needed. We heard from some that they found it difficult to mix with other individuals in the ward and share accommodation. One individual described the acute ward as being "like a jail but without the bars on the window". Another told us that they were angry when first admitted however, after time, realised that the staff were there to help. Some individuals told us that they were not allowed any time off the ward, but that there were plenty of activities to do, while others told us that they found it hard to fill their time.

In both wards, there were a few individuals that we spoke with who disagreed with their hospital admission and were unhappy with their treatment; we had further discussions with them about their rights. Individuals in the rehabilitation ward told us about their meetings with the doctor, and of their involvement in their care and treatment. One told us that they wanted a new doctor and social worker and wanted their freedom. After receiving feedback from one individual about their experience on the ward, we followed this up with staff and will continue to do so.

Individuals in the rehabilitation ward described staff as “caring”, “helpful” and “approachable”. One individual described the ward as the best that they had been in throughout the forensic inpatient care journey across Scotland.

Individuals were able to tell us about their treatment and care planning, and their participation at meetings, about feeling involved in their care and treatment, and of their active plans for discharge.

Nursing care plans

The care plans were in paper format, and we found them easy to navigate. We wanted to follow up on our last recommendation regarding care planning and to see what progress had been made.

The SCN told us about the piloting of new care plan documentation that had been developed by a working group established to improve care planning documentation and processes across NHS Grampian. We saw the new documentation and were able to see from reviewing files that the nursing staff were in the process of changing over all the care plans to this new format. We were pleased to note improvement in this area in the files we reviewed.

We saw evidence of detailed, comprehensive care plans, with regular reviews taking place that evidenced individual participation. The care plans we reviewed covered a wide range of needs. In the acute ward we saw a comprehensive care plan that was in an accessible read format, which supported the individual’s understanding of their care and treatment. We also reviewed a detailed continuous intervention care plan. In terms of engagement and participation, we saw that some individuals had signed their care pans, and others recorded that the individual did not wish to participate or sign their care plan.

We were pleased to see that the process of engaging an individual in their care planning process has improved since our last visit. We were made aware that there had also been a new evaluation form devised, however, as many of the care plans had recently been transferred to the new document, some care plans were not at that stage, so no evaluation had, as yet, taken place. The SCNs told us that a new audit form has been devised, which was being trialled at the time of our visit. The outcome of this will be taken back to the working group to see if further changes are required, before the documentation is rolled out.

We were pleased with the work that has been done around the care planning process and documentation, and we hope that having a robust audit tool in place, will ensure a consistent standard is maintained across the care plans in the wards; we look forward to reviewing this on our next visit.

We found good evidence of regular one-to-one sessions between individuals and staff, recorded in the files, that were detailed and meaningful, as were the daily nursing entries recorded in the notes.

Multidisciplinary team (MDT)

We were told that the MDT meeting continues to take place weekly and the MDT consists of three consultant psychiatrists, nursing staff, OT, forensic clinical psychologist, along with input from pharmacy. We were told that the provision of occupational therapy (OT) to the

wards has been reduced more recently, although there have been ongoing efforts to try and recruit to vacant OT posts. Staff and individuals that we spoke with told us about the valuable contribution that OT has in supporting individuals with their recovery.

We saw evidence in individual files that the forensic psychologist continues to be involved in developing the risk formulation plans for all forensic patients. The forensic service has two psychologists that provide input to individual's care and treatment, however at our last visit, we were told that one of the psychologists had left and that the service was actively recruiting for a replacement. We were pleased to hear that the post had recently been filled.

In the MDT meeting record, we saw that there was a recorded entry of who attended, along with a detailed update from the meeting, with outcomes and actions noted. We were told that individuals did not attend this weekly meeting however, the consultant psychiatrist met with the individual before or after the meeting, and that the individual had the opportunity to make any specific requests that they wished to be discussed at this meeting via the nursing staff. There was a section in the MDT meeting record that recorded individual requests however, the majority of those that we saw were blank, and there was not always a written record in the daily nursing notes; it was difficult to know if the individual had been asked or if they had no requests, or if they had not been asked. We suggested to the SCN that it would be helpful to record in the daily notes when the staff spoke with the individual about specific requests for the MDT meeting.

Several individuals were subject to Multi Agency Public Protection Arrangements (MAPPA) and 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; we found that these were clearly recorded, with timely outputs covering all key areas. We were pleased to see evidence of individual participation at these meetings, along with support from advocacy. The minutes of the CPA meetings were detailed and thorough, covering all aspects of the individual's care and treatment. We were pleased to see that these meetings were also attended by social work and mental health officers.

All care notes were in paper files, and we continued 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 pilot sites in the hospital that were testing the system, however as yet, there is no planned date for this to be rolled out to all services. This will be an opportunity for all records to become integrated, as there were some aspects of the current record management that are disjointed; all professionals record in their own records and have their own record management system. We suggested to managers that they needed to ensure that the new electronic system will fully meet their needs and lend itself to robust and detailed recording for all MDT professionals.

On the day of the visit, we were told that two individuals had been recorded as delayed discharge and we heard of the complexities around the active planning that continues to take place.

Use of mental health and incapacity legislation

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

We wanted to follow up on a recommendation from our previous visit, where we found that treatment was being given out with the authority of the Mental Health Act. Part 16 (sections 235-248) of the Mental Health Act sets out the conditions under which treatment may be given to individuals who are detained and who are either capable or incapable of consenting to specific treatments. We reviewed all individual treatment forms, along with medication prescription record, and we found several issues with the treatment forms (T2 and T3) that had been completed by the responsible medical officer (RMO). The Commission had received an action plan following last year's visit, as to how the wards were going to address the recommendation.

We were told that as part of the monitoring process, treatment forms would be reviewed at the MDT meeting, along with advice from pharmacy. We had a further concern that nursing staff were not checking what medication had been legally authorised at the time of administering this.

We found that a new T2 certificate that had been completed by the RMO, was not in the current prescription file that nurses used when administering medication; instead they were still referring to a previous version which had been highlighted as erroneous. We will follow up these issues with regards to individuals' treatment with the respective RMOs.

We were concerned about this lack of improvement, and the impact on individuals' rights, given that some individuals were receiving treatment out with authority of the Mental Health Act. We will escalate this matter to the senior managers.

We were told that the wards continued to have input from pharmacy, and we were aware that there have been further audits done across the Royal Cornhill Hospital site, following concerns we had on other visits with regards to Mental Health Act treatment certificates (T2/T3). We were aware that there was a plan to carry out further audits and we will link in with senior managers about the outcome of these.

The lead pharmacist had devised a good practice guide for staff which was inserted into each individual prescription kardex to act as an aid memoire, but clearly this guidance was not always being followed.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where an individual had nominated a named person, we would expect to find copies of this in the file. We saw examples where a named person had been nominated. This information was easy to find and clearly recorded.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act 2000 (the

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. Where appropriate, we saw completed s47 certificates, along with treatment plans.

Recommendation 1:
Managers must develop a robust audit system that will ensure all treatment certificates are current, that all prescribed psychotropic treatment is legally authorised, and that this is discussed and reviewed at the weekly MDT meetings.

Rights and restrictions

Section 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on individuals who are detained in hospital. Where an individual 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 are aware that in some areas, admission to a low secure (forensic) ward results in almost automatic designation as a specified person. This practice is incompatible with the principles of the Mental Health Act and not aligned 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 individual or to others if these restrictions were not put in place.

All individuals in both wards had been made a specified person, the same as we found on last year's visit. We discussed this further with nursing staff and RMOs who told us that each person was individually assessed and that this was not automatic practice across the wards. From the files we reviewed, we found that where an individual had been made a specified person that all specified person paperwork, was in place, however, there were four individuals where there was no reasoned opinion recorded by RMO. There was, however, specific care plans in place, which were detailed. The Commission is in the process of updating our good practice guidance around the use of specified persons and we will keep the service informed of when the guidance is available.

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

When we are reviewing individual 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 found copies of advance statements in some files that we reviewed, and others had recorded where an individual had chosen not to have one in place.

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

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that individuals 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 2:
Managers must ensure any decision to apply specified person legislation is made on an individual basis and that reasoned opinions, along with regular reviews are in place.

Activity and occupation

On our visit last year, we were told that the Blair Unit had just recruited a further activity nurse, to work across the unit, which meant that there were now two activity nurses in place. Individuals were able to tell us about the activities that they enjoyed and participated in, on and off the ward. Individuals told us about using the ward gym, cooking with the OT, and attending groups in the community. Some individuals showed us a copy of their weekly activity planners and told us how this helped them prepare for discharge to the community.

The staff told us that there had been an increase in the use of the gym in the ward and this was confirmed by the individuals that we spoke with, and whose care we reviewed. On the day of the visit there was the weekly coffee morning taking place in the forensic rehabilitation ward and we saw people from other wards in the Blair Unit attend this, accompanied by staff.

OT formed part of the MDT in the Blair Unit, and individuals told us about the input they had from OT as part of their care and treatment. On the day of our visit, we spoke to the OT about activities and input to the wards and were told that activities happen in groups and on an individual basis, depending on the individual's stage of their recovery. The OT told us that they would meet with the individual when they were admitted and carry out an assessment. The OT supported the person to link in with activities in their local community in order to aid their recovery, and work towards discharge planning. However, we also heard that there was no community OT in the forensic service, to provide follow-up once a person was discharged.

We were aware that there continues to be recruitment challenges to the vacant band 7 OT post to the Blair Unit; we will link in with managers to get an update with regards to OT provision.

In the forensic rehabilitation ward, there was a therapy kitchen which OTs used with individuals for rehabilitation purposes. We saw this on the day of the visit, and we heard from a few people that they enjoyed this element of learning new skills in preparation for discharge.

In the acute ward, individuals had access to a games room with a pool table, games console, TV and DVD player. There was a separate activities room in the rehabilitation ward where there were displays of individuals' artwork and there was also a full-sized snooker table that many people were using on the day of our visit.

We were pleased to hear that the adult learning tutor post had been filled, as this had been vacant at the time of our last visit. We heard from individuals about their access to this and the benefits of this resource whilst being in hospital.

Although the provision of OT to the wards had reduced due to vacancies, we found that there was still a good level of activity provision happening across both wards and this was recorded in the files we reviewed. We found that there was a real focus on the benefits of activities to individuals across the wards and with the addition of another activity nurse, along with the combination of OT input, this has enhanced the delivery of therapeutic provision to the individuals.

The physical environment

We wanted to follow up on the previous recommendations that had been made in relation to the accommodation, following on from 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 unit in the short, medium and long term.

Since our last visit, we are extremely concerned to see that there have been no improvements to the accommodation across both wards. The dormitories and individual rooms were bleak, and in desperate need of decoration.

Both SCNs and consultant psychiatrists had previously told us that there had been ongoing meetings to look at what was needed for individual care in the future across the Blair Unit, and we had gotten 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.

Accommodation in both wards consisted of single rooms and dormitories. Some individuals told us that they did not like to share, as the dormitory could often be untidy and noisy. We were told of works that continued to be on the risk register and how there were regular meetings and visits to review these. We were told that the unit had identified 13 high risk items that continued to be on the risk register. There continued to be various ligature points across the accommodation, and other work that was outstanding, such as flooring that needed replaced. We had heard of an incident where an individual managed to pull the metal air vents from the ceiling in the forensic acute ward. The ceiling had been patched up with a block of wood however there were still various other metal vents on the ward ceilings.

The forensic acute ward had a communal area where individuals ate their meals, watched television, and carried out activities. The rehabilitation ward had a lounge area, activity room, kitchen and gym. There was also a smaller kitchen where individuals were able to make a drink throughout the day. Both wards had access to an enclosed garden space, however there was a lack of interview space across both wards, and we found this to be an issue on the day of the visit.

Staff again told us about the impact of the environment on delivering safe individual care, particularly with significant ligature points, unsuitable furniture, and windows that were sealed, preventing fresh air into the ward.

'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 were 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 had changed. As the minister raised concerns with the health board regarding the state of the accommodation, we were unsure if the minister had followed this matter up with the health board and will therefore write to Scottish Government and the health board for clarification. We are also repeating our recommendation from our last visit.

Recommendation 3:
Managers must address the significant deficits in the physical environment and formulate a robust action plan to ensure the accommodation promotes individual safety, whilst protecting privacy and dignity.

Summary of recommendations

Recommendation 1:
Managers must develop a robust audit system that will ensure all treatment certificates are current, that all prescribed psychotropic treatment is legally authorised, and that this is discussed and reviewed at the weekly MDT meetings.

Recommendation 2:
Managers must ensure any decision to apply specified person legislation is made on an individual basis and that reasoned opinions, along with regular reviews are in place.

Recommendation 3:
Managers must address the significant deficits in the physical environment and formulate a robust action plan to ensure the accommodation promotes individual safety, whilst protecting privacy and dignity.

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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Mental Welfare Commission 2024