



## **Mental Welfare Commission for Scotland**

**Report on announced visit to:** The Blair Unit, Royal Cornhill Hospital, 26 Cornhill Road, Aberdeen AB25 2ZH

**Date of visit:** 7 August 2018

## **Where we visited**

The Blair Unit comprises the intensive psychiatric care unit (IPCU) forensic acute and forensic rehabilitation wards.

An IPCU provides intensive treatment and interventions to patients who present an increased level of clinical risk and require an increased level of observation. IPCUs generally have a higher ratio of staff to patients and a locked door. It would be expected that staff working in IPCUs have particular skills and experience in caring for acutely ill and often-distressed patients.

We last visited this service on 8 and 17 August 2017 and made the following recommendations: the need to review the mix of female civil and forensic patients in IPCU, the need for audit of mental health act paperwork, and for shower rooms to be ligature free.

On the day of this visit we wanted to follow up on the previous recommendations.

## **Who we met with**

We met with and or reviewed the care and treatment of 13 patients and one relative.

We spoke with the charge nurse and other clinical staff.

## **Commission visitors**

Douglas Seath, Nursing Officer

Ian Cairns, Social Work Officer

Paula John, Social Work Officer

## **What people told us and what we found**

### **Care, treatment, support and participation**

Several patients told us how nursing staff supported and involved them in discussions about their care and treatment. Many of the patients we reviewed were managed using the care programme approach (CPA). We heard from patients about their CPA reviews, how their named nurse will discuss with them the issues they want to raise at the review, and how they feel they can put their views across in these CPA meetings. Relatives are invited to CPA reviews with the patients' agreement.

Weekly Multidisciplinary Team Meetings (MDTs) take place, reviewing care and treatment of patients across the three wards. These meetings take up quite a bit of staff time. Whilst patients are not invited to attend, their views can be taken into

account by staff. Staff interviewed on the day did not see these large meetings as the best use of nursing staff time.

There were comprehensive risk assessments and management plans completed on standardised forms soon after admission. It was not clear when the risks were further reviewed. Care plans, on admission, were brief and focussed on initial needs. The subsequent follow-on recovery plans were variable and the review process was simply recorded by a date and staff signature, often with no written evaluation.

The content of care plans was mostly appropriate though not all were person-centred. There were very good psychology reports on file and evidence of good MDT working. In the forensic wards, there was evidence of good uptake of patients making advance statements. There was also appropriate use of interpreters for patients whose first language is not English to make sure patients are participating in discussions about their treatment.

#### **Recommendation 1:**

Managers should ensure that nursing staff include summative evaluations in patient care plans that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

### **Use of mental health and incapacity legislation**

Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) documentation was well maintained in personal files. Documentation authorising medical treatment under part 16 of the MHA was well ordered and we saw that prescribed medication was authorised appropriately on the relevant consent to treatment form (T2) and certificate authorising treatment form (T3). One patient did not have the necessary form of authorisation on file due to a misunderstanding, but when this was highlighted staff took action to remedy this on the day. Where this was appropriate, we also noted that associated high dose monitoring checks were thoroughly completed.

Not all patients in the forensic wards were specified persons, but those specified had clear care plans for the specific restrictions in place. It was clear that restrictions were related to the individual patients and assessed risks. One patient, who was specified for correspondence, had a clear record of why this was necessary, and how this restriction was applied in an individual care plan.

### **Rights and restrictions**

Sections 281 to 286 of the MHA provide a framework within which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to these sections of the Act and restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore

expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed.

Responsible medical officers (RMOs) are required to complete certain forms in relation to specified persons. We noted that the necessary notification forms were in place in the wards where this was appropriate and that the reasoned opinions were recorded on a separate form and attached. We also saw that specific restrictions being applied were well documented in care plans and that restrictions were being reviewed.

There was the issue of the pantry in the rehabilitation ward being locked because of one patient, though patients could still make hot drinks on request.

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/media/369925/human\\_rights\\_in\\_mental\\_health\\_services.pdf](https://www.mwcscot.org.uk/media/369925/human_rights_in_mental_health_services.pdf)

## **Activity and occupation**

A good range of leisure, recreational, and therapeutic activities appear to be available to patients in the wards. We heard a number of positive comments about activities, but we also heard a few comments from individual patients about activity often being limited due to staffing levels.

In the forensic wards, we heard that band three staff are allocated patients and take responsibility for preparing individual activity planners with patients. There is a gym, an activity/arts room and a full-size snooker table in the rehabilitation ward.

We were informed it can be difficult to motivate some patients in more formal activity and to be involved with groups, especially in IPCU where individuals are more acutely unwell.

### **Recommendation 2:**

Managers should ensure that activities are protected as an integral part of care provided and that staff are available to support this.

## **The physical environment**

There were a few complaints about the ward environment being too hot, windows not opening and lack of fans. There were also complaints about the state of the showers in the rehabilitation ward, some having mould and damp.

Ligature prevention work, which was due to take place, has been postponed pending a refurbishment of the unit with dormitories planned to be converted to single rooms with en-suite.

### **Recommendation 3:**

Managers should ensure that any maintenance or corrective work to the ward environment should not be unnecessarily postponed due to the prospect of an, as yet undated, impending ward upgrade.

### **Any other comments**

Although there are no purpose-made facilities for children visiting in the unit, there are family rooms elsewhere in the hospital which can be booked by prior arrangement for this purpose. This issue had been raised by a relative but it was problematic because the request had been at very short notice.

Some of the patients had significant physical conditions. These were clearly followed up appropriately and regular health checks were in place.

### **Summary of recommendations**

1. Managers should ensure that nursing staff include summative evaluations in patient care plans that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.
2. Managers should ensure that activities are protected as an integral part of care provided and that staff are available to support this.
3. Managers should ensure that any maintenance or corrective work to the ward environment should not be unnecessarily postponed due to the prospect of an, as yet undated, impending ward upgrade

### **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

Alison Thomson, 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 MWC is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors. Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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