Mental Welfare Commission for Scotland

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

Date of visit: 20 August 2024

Where we visited

The intensive psychiatric care unit (IPCU) is an eight-bedded locked unit that provides intensive treatment and interventions to individuals that present with an increased clinical risk and are likely to require a higher level of observation.

The unit is based in the Blair Unit in the main Royal Cornhill Hospital. The Blair Unit compromises of the IPCU, a low secure forensic acute ward, and a forensic rehabilitation ward.

The IPCU admits individuals known to the general adult psychiatric (GAP) services and forensic psychiatric services. The other two wards in the Blair unit solely admit individuals with a forensic need/background.

The IPCU is a mixed-sex unit, and on the day of this visit, there were five individuals in the ward, however one had recently been transferred to the general hospital. Out of the five individuals, three were known to forensic services and two to GAP services.

Individuals could either be admitted to this unit via the courts, due to criminal offending behaviour, transferred from prison due to mental ill health or following a referral from a GAP consultant. Where a clinical need had been identified following a referral from a GAP consultant, the Blair unit consultant forensic psychiatrist, who was responsible for admissions and referrals on that specific day would determine if the criteria admission to the IPCU was met.

We asked managers about accessibility to this unit by GAP services, given that the decision to admit was made by the forensic consultant. We were told on our visit last year that the IPCU patient pathway was being reviewed. Managers told us that this was still under review and that there had been a working group set up last year that involved representatives from GAP services. We will request an update from managers regarding this.

Following our last visit, we made recommendations regarding care planning, restrictions, environment, access to psychology services, and accessibility of the IPCU to GAP services. The response we received from the service was outlined in a detailed action plan. With regards to psychology provision in the IPCU, managers informed us that they currently did not have the resource to provide psychological therapies however highlighted this as a service development priority.

On the day of this visit, we wanted to follow up on the previous recommendations and look to hear how the service was meeting these.

Who we met with

We met with three individuals and reviewed the care records of four individuals.

We spoke with the senior charge (SCN) nurse, ward-based nursing staff and consultant psychiatrists.

We made contact with the local advocacy service.

Commission visitors

Tracey Ferguson, social work officer

Lesley Paterson, senior manager

What people told us and what we found

Feedback from individuals about staff was mostly positive, where individuals described staff as “good”, “caring” and “approachable”. One individual told us that the staff checked in on them regularly and that they liked this, as it made them feel valued and talking with staff really helped. Another individual told us that being in hospital had really helped them. A few individuals were able to tell us about their involvement in their care and treatment and how they met with their doctor regularly.

Individuals told us about their time off the ward and of the activities that they enjoyed with the activity nurse and occupational therapist. However, we heard from one individual that there was not much to do. We heard from another individual that they were not happy about the lack of access to their mobile telephone.

Individuals told us about their current accommodation in the unit and how they particularly did not like having to share a dormitory with another person with only a curtain between them both, offering no privacy whatsoever and of having to share bathrooms where there was a mix of male and females in the ward. One individual told us of how they had personalised their bedroom, which helped them to feel more comfortable. Another individual told us that they liked the quiet room as the staff had put lots of sensory equipment in the room which helped them to feel safe.

Managers told us that they continued to have a daily huddle to discuss bed pressures, individual admissions and discharges, along with staffing numbers, to ensure safe delivery of individual care across the Blair Unit.

Individuals who are admitted to an IPCU require intensive support and treatment to assist their recovery during the most acute phase of their mental ill health. Due to the lower number of individuals in the setting, along with a higher staff ratio, staff felt that they had the time to deliver this in a person-centred way. The SCN told us that the staff team required to work across the Blair Unit, depending on clinical demand and often they were working with individuals at different stages of their recovery.

There are no forensic mental health beds for females, out with the IPCU and we were told that the females who were in the IPCU and were managed by forensic services tended to remain in this enhanced setting until they were ready for discharge, even when they no longer required care in the IPCU.

The SCN told us about continued proactive efforts to recruit staff to vacancies and it was positive to hear that they had recently recruited to many vacant posts through new graduate recruitment.

Care records

Managers told us that some documentation had recently been transferred to the electronic system TRAK, which is being rolled out across NHS Grampian. We

accessed individual electronic files on the day of the visit as well as paper files, which were still in place. The SCN told us that the plan was for the unit is to eventually have all recording and documents transferred over to the electronic system.

We were told that all the ward-based staff and forensic consultant psychiatrists record their daily contact with individuals on TRAK and the weekly multidisciplinary team (MDT) meetings were also being recorded on this system. We are aware of plans to roll this out to all wards across NHS Grampian which will allow records to become integrated and enable GAP consultant psychiatrists to view the electronic record.

Care, treatment, support and participation

We had been made aware on our visit last year that there was a working group across the Royal Cornhill site that was looking to improve care planning documentation and processes and that the SCN from the IPCU was leading on this. On this visit we saw the new documentation in place. We found that the majority of care plans in place were detailed, person-centred and identified goals, with regular reviews taken place. Where we found that some important details were missing, we provided examples of these to managers.

We found that following a review, care plans had been updated and reflected current need. We found that participation in the process had improved, where some individuals had either signed their care plans or had a copy and knew about their goals. Where some had not been signed, there was a reason recorded on the document as to why this was the case. The SCN told us about the new audit tool that had been devised as part of the improvements and we were told that there had been an audit carried out across the other wards in the hospital to see how the tool was working. We were pleased to see the implementation of the new documentation in the IPCU, along with the regular audits that were being carried out as part of the improvement work.

We found detailed daily entries by nursing and medical staff that were relevant, meaningful and provided an update on the level of progress of the individual's care and treatment, along with incorporating their views.

In terms of risk assessments and risk management plans, we found a rapid risk assessment in each of the care notes, and details of risks included in care plans. However, there was no separate, comprehensive risk assessment and risk management plan.

We discussed this further with the SCN and we were told that due to the transfer of some records onto the electronic system, some documents had been sent to medical records to be uploaded onto the electronic system. We suggested given that

the service was in an interim period between paper files and electronic files, important documents such as risk management plans should be kept in the paper file until the document had been uploaded onto the electronic system.

Managers also told us that this unit and all other wards in the hospital, were implementing new risk assessment and risk management documentation, as the assessment and care planning booklet that was previously in place was no longer being used and the new documentation was to be on TRAK.

Multidisciplinary team (MDT)

There were three consultant forensic psychiatrists who covered the Blair Unit and who had responsibility in determining admissions to the IPCU. For individuals who were admitted to the IPCU and did not have a forensic background, we were told that the GAP psychiatrist would continue to be the individual's responsible medical officer (RMO). Whether a person was detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or not, a GAP consultant would continue to be responsible for reviewing the care and treatment. This was outlined in the patient pathway document that we had received a copy of. We were told that this document was still under review.

We were told that MDT meetings continued to take place weekly, and the meeting was attended by the consultant forensic psychiatrists, nursing staff, occupational therapy (OT) and forensic clinical psychologist. We were pleased to hear that all individuals in the IPCU now had access to OT services and we heard from individuals and staff about the benefits to care and treatment.

However, we were told that access to psychology services was not available for all individuals in the IPCU and that only individuals who were being looked after by forensic services were able to access this service.

When we reviewed one individual's care, we were able to see how this individual would have benefitted from psychology input. We continue to be concerned that individuals in the IPCU do not have equitable access to psychological services. As we made this recommendation following our last visit and there has been no progress, we are therefore repeat this recommendation. We will also ask senior managers to provide us with ongoing updates regarding this lack of provision.

Recommendation 1:

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

The electronic MDT meeting record provided a detailed overview and update of the individual's care and treatment and recorded who attended this meeting, along with outcomes and actions. We felt that the new electronic recording format was robust

and covered all necessary aspects of a person's care and treatment; this included ongoing monitoring of physical healthcare.

We were told that individuals did not attend the weekly MDT meeting however, the nursing staff met with individuals to discuss any requests for the meeting. The forensic consultants also met with individuals before or after the meeting. From our review of the case records, we saw evidence of this and also that the individual's views were sought.

However, when the individual was under the care of a GAP psychiatrist, there was confusion and lack of input to this meeting. We discussed one case where it was recorded on some documents that the forensic psychiatrist was the responsible medical officer (RMO), and carrying out some RMO duties although this individual was under the care of GAP services and had a GAP RMO, who was not carrying out RMO duties or involved in decision making about the individuals care and treatment.

This situation was confusing for us, for staff and for the individual; the lack of clear lines of responsibility carried an inherent risk. On reviewing another individual's files, we could see that the GAP consultant who was the appointed RMO had not reviewed the individual since their transfer to the IPCU, which had been several weeks ago. Staff told us that the review of individuals by GAP psychiatrists was inconsistent.

Following our visit in 2022, we made a recommendation in relation to the service developing a clear protocol between GAP and forensic services. This was following concerns raised by staff and individuals about the decision-making process regarding care and treatment where an individual's RMO was from GAP services. We were provided with an action plan and told that where a GAP consultant was the RMO, that a review would take place after three days of transfer to the IPCU and then weekly thereafter, and the GAP consultant would join the Blair Unit MDT meeting.

Despite this clear protocol being in place, we found that this practice was not consistent and that it was the forensic psychiatrists who were mainly taking the lead and fulfilling the RMO duties.

Recommendation 2:
Managers must ensure adherence to the IPCU protocol/pathway that outlines RMO / consultant psychiatrist duties and responsibilities for all individuals who are admitted to the IPCU and accordance with this should be monitored.

Use of mental health and incapacity legislation

On the day of the visit all five individuals were detained under the Mental Health Act or the Criminal Procedures (Scotland) Act 1995 (CPSA) and we found that the detention paperwork was in order.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals 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 where required, apart from one. We discussed this further with the forensic consultant psychiatrist and SCN who agreed to follow up on this matter.

The unit had recently moved to the electronic prescribing system, HEPMA (hospital electronic prescribing and medicines administration) and the SCN told us that the staff had managed this transition well. All treatment certificates were kept in individual's files and were easily accessible.

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 found copies of these in the care notes.

Rights and restrictions

The SCN told us that where an individual was on continuous interventions, there was a review process in place. From reviewing the care records, we found where individuals had been on an enhanced level of observation, this had been reviewed and discussed at the MDT meeting and the decision recorded. We were also told that every individual's time out of the ward was reviewed at each MDT meeting and recorded in their care plan. We saw this in the care records.

We wanted to follow up on our last recommendation with regards to restrictions. Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a person is a specified in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied.

The staff office had a white board on the wall, which provided basic essential information about individuals. It was recorded that all individuals had been made a specified person, under safety and security measures of the Mental Health Act. However, we were told that there was one individual where this recording was incorrect, as they were not subject to specified person legislation. Due to the location of the board, information was easily accessible for others to view although there was a blind in place which could cover the board; unfortunately, the board was not covered on our initial entry to the ward.

We found specified person paperwork, along with reasoned opinion to be in order however, we had a further discussion with SCN about one individual's restrictions. NHS Grampian had a blanket restriction policy in place where prohibited items could

not be brought into the unit and other items, which were deemed to be restricted, could be accessed only after individual risk assessment had taken place.

We saw that some individuals had been asked to sign a form to consent to items, such as mobile telephones being removed. However mobile phones did not feature on the restricted or prohibited items list. We saw that some individuals had signed and agreed to the removal, but this was not the case for everyone. Although the form provided individuals with information about accessing items, there was no information provided as to what their rights would be where a person refused to sign the form or were unable to give informed consent.

We reviewed one individual's care records where they had not signed the consent form and were unhappy at not being able to access their mobile phone when they wished to do so. This lack of clarity where a person refused to / could not consent concerned us.

Recommendation 3:
Managers must ensure that all restrictions placed on individuals are lawful and that there is a clear process for when an individual does not or cannot give informed consent to the removal of personal items and does not meet the criteria for specified person legislation.

When we are reviewing individual's files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 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 and we found where a person had made one, there was a copy in the case record.

The unit had good links with the advocacy service based in the hospital, and supported individuals with their rights.

The Commission has developed *Rights in Mind.*[1] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

The Blair Unit had two activity nurses who provided input across the three wards. The SCN told us that one of the activity nurses was employed to cover only the IPCU. We met with the activity nurse and continued to hear how this role enhanced the delivery of therapeutic provision to individuals, aiding towards their recovery.

[1] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

We were told that activities were mainly on a one-to-one basis although small groups could be delivered, where appropriate.

The activity nurse would either work with individuals on or off the unit, depending on their activity planner and /or suspension plans approved by Scottish Government, which permitted time off the ward. We were told that depending on individual needs, the activity nurse would undertake the activity on a one-to-one basis or with other staff, that included OT.

The unit 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 they got from these. We found evidence of this in the individual's files that we reviewed, along with the activity being linked to the individual's care goals in their care planning documentation. Staff told us that all individuals had access to OT and that their input towards recovery was invaluable.

The physical environment

We wanted to follow up on the recommendation we made in relation to accommodation following our last visit. We saw that new dining room furniture had been purchased for the sitting/dining area and that the quiet room had been redecorated and was being used as a sensory room, which was frequently used.

From viewing the physical environment, we were concerned and disappointed to see that once again, there had been no significant improvements made to the accommodation since our last visit.

This unit had a mixture of single room and dormitory style accommodation, none of which were ensuite. The shared dormitories continued to have only a curtain between individual's space that offered no privacy or dignity, and there were various ligature points identified across the unit. Windows in the unit did not open and the only fresh air that came into the unit was when the door which led to the enclosed garden was opened. The rooms were exactly the same as last year, where large blocks of wood had been fitted on parts of the wall to cover holes and damage. The unit only had one communal area in which individuals ate their meals, watched TV, carried out activities and played pool.

Males and females continued to have shared bathrooms, that were in need of upgrade.

The Barron Report: Independent Forensic Mental Health Review was commissioned by the Scottish Government and published in 2021. This report was particularly critical of the current dormitory style in the Blair unit, including the IPCU. The report made specific recommendations regarding the physical environment of forensic services and for health boards to address these issues.

In our last four visit reports, we have continued to highlight our concerns and make recommendations about the physical environment in the Blair Unit. We have continued to raise our concerns with senior managers in NHS Grampian and the Scottish Government and are concerned that nothing had changed.

We are aware that there has continued to be ongoing discussions with the chief executive and senior managers regarding the environment and that since our last visit, there had been further visits to the unit by the new leadership team and further plans for representatives from the Scottish Government to visit the unit again

We continue to be significantly concerned about the accommodation in the unit, as was a previous minister for mental health and wellbeing, who visited the Blair unit in May 2022. We have continued to request an update from senior managers at NHS Grampian, who also share our concerns and informed us that the Blair Unit features as their highest area of priority. The chief executive had provided an update to the Commission in March 2024 and informed us that a scoping exercise was being undertaken in regard to essential works and that a forensic services accommodation project board had been set up to lead and oversee the improvement work.

We concur with the views of the Barron Report, in that individuals who require to be admitted to an IPCU should not have to share accommodation and should have their care, treatment and support provided in a welcoming and therapeutic environment. We therefore urge senior managers of NHS Grampian to consider this when they are making future improvements. We will continue to request an update from senior manager of NHS Grampian of the Blair Unit accommodation.

Recommendation 4:
Senior managers must progress the work of the forensic services accommodation project board to ensure that the IPCU environment is safe, welcoming, therapeutic and fit for purpose.

Summary of recommendations

Recommendation 1:
Managers must ensure that all patients in the IPCU have equitable access to psychological therapies.

Recommendation 2:
Managers must ensure adherence to the IPCU protocol/pathway that outlines RMO / consultant psychiatrist duties and responsibilities for all individuals who are admitted to the IPCU and accordance with this should be monitored.

Recommendation 3:
Managers must ensure that all restrictions placed on individuals are lawful and that there is a clear process for when an individual does not or cannot give informed consent to the removal of personal items and does not meet the criteria for specified person legislation.

Recommendation 4:
Senior managers must progress the work of the forensic services accommodation project board to ensure that the IPCU environment is safe, welcoming, therapeutic and fit for purpose.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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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