mental welfare commission for scotland

Mental Welfare Commission for Scotland

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

Date of visit: 15 December 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

The intensive psychiatric care unit (IPCU) is an eight-bedded 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. On the day of our visit, there were seven people on the ward with one vacant bed.

The IPCU is based in the Blair Unit in the Royal Cornhill Hospital. The Blair Unit compromises of the IPCU, a low secure forensic acute ward, and a forensic rehabilitation ward. The IPCU is a mixed-sex unit and 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 Blair Unit is currently undergoing refurbishment to address concerns raised about the environment in line with the Independent Review of Forensic Mental Health Services (the Barron Report) and in order to reduce the risk profile for the unit. This work was ongoing at the time of our visit and the IPCU had been moved into the low secure forensic acute ward two weeks prior to our visit.

Individuals could 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 for admission to the IPCU was met.

We last visited this service in August 2024 on an announced visit and made recommendations on restrictions, the environment, access to psychology services, and accessibility of the IPCU to GAP services. The response we received from the service was outlined in an action plan. We were pleased to hear from the service that psychology could now be accessed by all individuals in the IPCU and was no longer dependant on them being open to forensic services.

On the day of this visit, we wanted to follow up on the previous recommendations and hear about the impact and progress of the refurbishment works.

Who we met with

We met with three people and reviewed their care records, and the records of another individual. Unfortunately, no relatives requested to meet with us.

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

We also contacted and received feedback from local advocacy services for Aberdeen City and Aberdeenshire.

Commission visitors

Susan Hynes, nursing officer

Kathleen Liddel, social work officer

What people told us and what we found

Feedback from individuals about staff was mostly positive, where individuals described the majority of staff as "good", "caring" and "approachable". One person felt there was a difference between the day and night shift staff, reporting the day staff were more considerate and compassionate. There was an intimation from this person that bank staff were not as experienced or skilled in managing the needs of individuals in an IPCU environment.

Two individuals told us that they had regular one-to-ones meetings with their doctor and felt this really helped them understand their treatment plan. Another felt they were not listened to by their responsible medical officer (RMO) and their care was overly restrictive. On review, we found the level of restriction proportionate to the person's needs at that time.

All individuals we spoke to felt they were treated with respect. Two individuals we spoke to mentioned that although they received good feedback from MDT meetings and were asked for their views before the meeting, they would prefer to attend in person.

People told us about their time off the ward and the activities that they enjoyed with the occupational therapist (OT). We heard from one individual that there was not much to do if you did not have time off the ward, although staff did do some activities with them. We heard from another individual that they were not happy about the lack of access to their mobile telephone and social media; we found a care plan and legal authority was in place in relation to these restrictions.

We were keen to hear about any impact of the move from the IPCU into the temporary accommodation. All the individuals and staff we spoke to were positive about the move and felt it had been managed well. People spoke of being involved in the process and being able to ask questions; we heard how advocacy had been used to support this.

People told us that the ability to get fresh air had improved as the windows opened and they reported the move had been "fine" and "no bother". We were told during the refurbishment that the low secure forensic acute ward had moved to share a space with the forensic rehabilitation ward. The SCN explained that the low secure forensic acute beds had been reduced from eight to six during the refurbishment and due to being housed in a rehabilitation environment with less environmental security, there was an increased forensic demand on IPCU beds. On the day of our visit all the beds in the IPCU were being used by individuals who were known to the forensic services.

Managers told us that they continued to have a daily huddle to discuss bed pressures, individual admissions and discharges, along with staffing numbers, which all helped 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 there being fewer individuals in the IPCU, along with a higher staff ratio, staff felt that they had the time to deliver care in a person-centred way, although on the day of our visit, there was a high level of acuity with two individuals who required increased input from staff.

The SCN told us that the staff team were 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 were no forensic mental health beds for females out with the IPCU. We were told that the females who were in the IPCU and were managed by forensic services, tended to remain in this setting until they were ready for discharge, even when they no longer required care in the IPCU.

We were told there had been a recent staffing review which showed a requirement for an additional 10 health care support workers and a half-time charge nurse. These posts were in the process of being recruited to and were expected to have a positive impact on the ability to deliver enhanced therapeutic input in the ward.

Care, treatment, support, and participation

Care records

Managers told us that care planning documentation had recently been transferred to the electronic system TRAKCare, which was being rolled out across NHS Grampian.

The SCN told us that the transition had gone fairly well but the service was aware that there remained some work to do with some staff, to support the transition to electronic care planning. We were told that all the ward-based staff and forensic consultant psychiatrists recorded their daily contact with individuals on the system and the weekly multidisciplinary team (MDT) meetings were also being recorded on TRAKCare.

We found the system easy to navigate and were able to access documentation easily.

Care plans contained detailed information about specific interventions to meet identified needs. The structure of care plans was also clear and understandable, with plans identifying needs, agreed goals, and the required interventions to meet these goals. The detail in the support plans developed by the nursing team was excellent, with interventions that were clear, detailed and measurable. Care plans were regularly reviewed and updated with progress towards the goals noted and interventions evaluated in the care records.

Some of the care plans we reviewed could have been more person-centred. There was some evidence in the records of individual involvement in the care planning

process; for example, it was documented that a person had been given a copy of their care plan. We also saw information that indicated when an individual was unable to engage in discussions about their care plans. We recognise that it can be difficult to evidence how staff are working with people and involving them in care planning and we would encourage the service to continue to consider participation and how this can be reflected in electronic care plans.

We found detailed daily entries by the nursing team; these were relevant, meaningful and provided an update on the level of progress of the individual's care and treatment, along with incorporating their views. We found evidence of regular one-to-one meetings between individuals and nursing, medical and other members of the MDT.

We were told the risk assessments and management plans had recently moved to the electronic TRAKCare system. In the care records we reviewed, we found that full risk assessments had been completed for individuals, but completion of care plans to manage the identified risks was inconsistent.

Some identified risks lacked a care plan, and risk management plans were not always completed comprehensively. While risk assessments identify risks, they are insufficient on their own without a clear, co-ordinated plan that translated the identified risks into proportionate, therapeutic interventions. A comprehensive risk management plan ensures that risks are actively mitigated through consistent multidisciplinary actions, clear roles and responsibilities, and person-centred strategies.

Recommendation 1:
Managers should ensure that all risk assessments provide clear and comprehensive information on current risks, are supported by a detailed risk management plan and are reviewed regularly to ensure they remain accurate and reflective of the individuals' needs.

A risk management plan would support continuity of care, reduce reliance on restrictive interventions, promote recovery, and provide defensible, transparent decision-making that would protect individuals, staff, and the organisation.

Twice daily, a dynamic assessment of situational aggression (DASA) was completed for everyone. These gave an indication of the level of risk that helped inform the staff group at each handover of any potential risk of aggression in the unit and was used to inform the appropriate staffing level required.

Multidisciplinary team (MDT)
There were three consultant forensic psychiatrists who covered the IPCU and who had responsibility in determining admissions there. 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 RMO, regardless of whether a person was detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or not. This was outlined in the patient pathway document that we received a copy of.

At the time of our visit, all the individuals in the IPCU were receiving care under a consultant forensic psychiatrist so we were unable to review the adherence to the IPCU patient pathway which outlined RMO /consultant psychiatrist duties and responsibilities. On our last visit, there had been a recommendation that managers should ensure that there was adherence to this pathway. This was following some confusion for individuals and staff about the decision-making processes, regarding care and treatment, where a GAP consultant was RMO. Staff reported that the situation had improved and the pathway was now being followed.

We were told that MDT meetings continued to take place weekly, and the meeting was attended by the consultant forensic psychiatrists, nursing staff, OT, forensic clinical psychologist, and pharmacy. We also heard the community mental health teams would attend as needed, although this could be more difficult for the Moray team.

We were pleased to hear that all individuals in the IPCU now had equitable access to psychology services, which had been a recommendation after three of our previous three. We heard from individuals and staff about the benefits psychology input had to people's care and treatment.

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 there could have been additional detail of the discussion in the meeting that could then have been added to the meeting summary, to describe how decisions were reached.

We were told that individuals did not attend the weekly MDT meeting, however the nursing staff met with individuals to discuss any requests prior to the meeting taking place. The forensic consultant psychiatrists also met with individuals before or after the meeting. From our review of the case records, we saw evidence of this and that the individual's views were sought. Some individuals we spoke to voiced that they would like to attend their meeting and be more involved in the discussions about their care.

Use of mental health and incapacity legislation

On the day of the visit, all seven people in the IPCU were detained under the Mental Health Act or the Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure Act) and we found that all of 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 in place, where required and corresponded to the medication being prescribed, apart from one medication prescribed for an individual.

We discussed this further with the RMO and SCN who agreed to follow up on this matter. In the cases where a T2 was authorising treatment there was an accompanying signed consent form from the person agreeing to treatment. We were told these certificates were reviewed and checked for accuracy at each team meeting.

All documentation relating to the Mental Health Act and the Criminal Procedure Act, including certificates around capacity to consent to treatment were easily accessible, in-date, and available for nursing staff when dispensing medication.

Anyone who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a named person has been nominated, we found details of this in care records.

Rights and restrictions

All the individuals we met with were clear about their legal status, as were the staff. All individuals had access to advocacy and legal advice if they wished and were aware of their rights of appeal.

The IPCU operated a locked door policy, in keeping with the needs of the people receiving intensive treatment there. We saw a copy of the policy and a sign explaining the entry system at the entrance of the ward.

The SCN told us that where an individual was on continuous interventions, there was a review process in place, and we found this documented in the care plans. This had been reviewed and discussed at the MDT meeting and the decision recorded. There was a care plan detailing the interventions required to support the person, the review process, and goals explaining the steps required to reduce the level of intervention.

We were 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 recorded in the care records. Where an individual was unable to leave the ward, they were able to access the secure garden area for fresh air.

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 an individual is a specified person and where restrictions are introduced, it is important that the principle of least restriction is applied.

We were keen to hear from the service how the recommendation from last year's visit that all restrictions placed on individuals were lawful and that there was a clear process for when an individual does not or cannot give informed consent to the removal of personal items and they do not meet the criteria for specified person legislation. We were told that a protocol is under development by the Blair Unit policies and procedures working group and should be completed shortly. We will follow this up with the service.

Where specified person restrictions were in place under the Mental Health Act, we found specified person paperwork, along with reasoned opinion for all individuals. We reviewed two individuals and found that their care records required more specific detail about the type of item that was specified and the risk it posed in order to justify its removal. This was discussed with the individual's RMO who agreed to follow this up. There were clear care plans detailing the restriction, why it was in place and how it should be managed on the ward.

When we are reviewing individuals' files, we look 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. We found two copies on file and saw evidence there was ongoing discussion with individuals on the ward about these.

The unit had good links with the advocacy service based in the hospital, and these services supported individuals with their rights. There was collective advocacy in the ward to support individuals give feedback about the recent move and ongoing refurbishment work in the unit.

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 IPCU had one activity nurse. We had heard during our last visit how this role has enhanced the delivery of therapeutic activity to individuals, aiding towards their recovery.

Unfortunately, due to low staffing numbers and higher levels of acuity, this nurse was frequently included in staffing numbers and their capacity to support activity had been reduced. This was highlighted in the feedback we received from individuals and in the recording of one-to-one activity in the care records.

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

The activity nurse role is planned to move into the general nursing staffing compliment, to coincide with a planned increase in nursing staffing in the unit. This would allow for the nursing team to more involved in offering activities in the ward and reduce reliance on an individual role. We would hope to see an increased variety of activity offered to individuals who are unable to leave the unit at our next visit.

There continued to be a good level and range of activities offered to those individuals who are able to leave the ward. We found evidence of this in the records we reviewed, along with the activity being linked to the individual's care goals in their care plan documentation.

People told us how they found this helpful and beneficial to them; staff told us that all individuals had access to OT and that this input was invaluable in their recovery journey.

The physical environment

The IPCU was temporarily relocated to another area of the Blair Unit. The layout of the ward consisted of four single rooms and two two-bedded dormitories; none of these were en-suite. There were four shower rooms and one bathroom with one shower room that was female only. The shared dormitories continued to have only a curtain between each bed area, which offered virtually no privacy or dignity.

The living area / dining room was bright, pleasantly furnished and there was access to a secure garden area. Staff and individuals in the ward all commented on how much they appreciated the ventilation and the ability to open windows for fresh air, which was part of the refurbishment.

The ligature reduction work had been completed in the bedroom and bathroom areas; the communal areas had not been included in this work. There was access for all individuals to a secure garden area which we heard was enjoyed by those who were unable to leave the ward. We saw rights-based information displayed on the walls along with information about the Mental Welfare Commission, advocacy, and carers support.

The Barron Report was published in 2021. This report was particularly critical of the current dormitory style accommodation 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 five visit reports, we have continued to highlight our concerns and make recommendations about the physical environment in the Blair Unit. We were disappointed to hear that the refurbishment of the IPCU and Blair Unit will not include installing partition walls in the dormitory area of the ward.

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 are therefore repeating our previous recommendation and will follow up with senior managers accordingly.

Recommendation 2:
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 should ensure that all risk assessments provide clear and comprehensive information on current risks, are supported by a detailed risk management plan and are reviewed regularly to ensure they remain accurate and reflective of the individuals' needs.

Recommendation 2:
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 an individual's care, treatment, and support are 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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk