mental welfare
commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to: Royal Cornhill Hospital, Loirston and Strathbeg Wards, Cornhill Road, Aberdeen, AB25 2ZH

Date of visit: 13 January 2026

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

NHS Grampian's inpatient learning disability service consists of Loirston and Strathbeg Wards, which are located at the Royal Cornhill Hospital site in Aberdeen. They also provide a service to individuals from Highland, and the islands of Orkney and Shetland.

Loirston is an eight-bedded, mixed-sex ward that provides assessment and treatment for adults with a diagnosis of a learning disability and/or autism, who have a psychiatric illness and/or present with behaviour that is complex to manage. On the day of our visit, there were five people on the ward.

Strathbeg is an eight-bedded ward that provides admission for adult males with a learning disability diagnosis, who require close supervision in a secure environment because their behaviour may be harmful to themselves or others. Some individuals who had been admitted to this ward had come via the forensic pathway. On the day of our visit there were six people on the ward.

Admissions were capped at 13 people across both services. This cap has been in place for some years due to the complexity of need and the requirement that a high proportion of people receive enhanced levels of care, including individuals on a continuous two-to-one or three-to-one basis.

We last visited this service in June 2024 for an announced visit and made recommendations that a seclusion policy should be drafted and implemented and that functionality assessments and an improvement plan be drawn up relating to the physical environment for both wards. These recommendations had also been made at our visit in 2023 and we noted that NHS Grampian have not had a seclusion policy in place for several years.

The response we received from the service detailed clear actions to be taken and we wanted to follow up on progress. We also wanted to hear about individuals whose discharge from hospital was delayed, as this had been an ongoing issue over several years.

Who we met with

We met with nine people across both services and reviewed the care records of seven of those. We also spoke with three relatives.

We spoke with the senior charge nurse (SCN) for each of the wards, the nurse manager, the nurse consultant, the lead occupational therapist (OT) and the consultant psychiatrist.

We had conversations with staff through the course of the day, including the clinical nurse specialist who worked across both wards and newly qualified nursing staff and a student nurse.

Commission visitors

Audrey Graham, social work officer

Susan Tait, nursing officer

Tracey Ferguson, social work officer

Susan Hynes, nursing officer

What people told us and what we found

The relatives that we spoke to were happy with the quality of care being delivered to their loved ones. We heard from family members about good communication with the ward, although one family member said they would like to be more involved. We heard from ward staff about how they considered the individual needs and circumstances of family members, to inform them about how best to communicate with and involve them.

The SCN's told us about the recent development of 'shared decision-making councils' for both wards, involving staff, individuals and family members. We look forward to hearing more about how these progress.

It was good to hear about staff consulting family members on what may need to be considered in delivering care and support to individuals, relating to their spiritual and cultural needs. We heard that specific dietary requirements were provided for.

We had several discussions with staff which evidenced a focus on what the individual could do and on maximising and building on existing skills. Discussions further evidenced an openness to positive risk taking in terms of supporting individuals, for example, to access the local community and use technology like interactive gaming.

We heard from one individual that the staff were "amazing". Themes which were evident from discussions with individuals and from our observations, were of a caring and empathic staff team across both wards. We saw that staff noticed signs of distress quickly and we saw skilled and considerate responses. Warm and humorous interactions between individuals and staff were evident through the course of the day.

We heard from staff that there was good peer support in the wards and that SCNs were open and approachable. It was evident in discussion with both SCNs that they valued their staff highly. A student nurse on placement told us that their experience had been very positive, with staff being supportive and open to sharing their knowledge.

Both SCNs told us that the number of individuals requiring continuous interventions, to ensure their safety or the safety of others and to manage behaviours that challenged, was usually high on both wards. We heard that on the day of the visit, there were five people requiring this level of care and support in Loirston ward, including one person who required the support of two staff at all times and one person who required three staff.

There were three people on Strathbeg Ward requiring continuous interventions; one required one staff member, one required two and one required three staff. We heard

that across both wards they generally needed at least 20 staff just to provide the level of continuous interventions required and that this was very challenging to manage at times. We did hear from individuals and staff that this sometimes limited opportunities to accompany individuals to activities in the community.

SCNs told us of the continuing challenges with recruitment of learning disability specialist nurses and that this was noted on the organisation's risk register. We heard that while only around half of nursing staff across both wards were learning disability nurses, this was an improvement. We were told that work was ongoing with the universities, including training a number of health care support workers via the Open University.

A clinical nurse specialist post had been created around 18 months previously to work across both wards. We heard that the postholder had made a positive impact in terms of supporting staff who were not specialist learning disability nurses, freeing up time for the SCNs who would have previously covered this. They had also created a learning disability focused induction to support staff.

Care, treatment, support, and participation

We found the care plans we reviewed to be of a high standard. They were detailed and provided a holistic picture of individual needs and risks. The interventions specified were descriptive, clear and linked well to identified goals. This was particularly important as we heard that it was necessary to employ bank staff regularly, who may not always be familiar with individuals or be specialists in learning disability.

We saw evidence that care plans were reviewed and updated regularly, however reviews were often brief, and the process could have been enhanced by including increased reflection on what interventions had worked for the individual, or not, and the potential reasons for this.

We were pleased to see examples of pictorial care plans, social stories and visual planners being used. We noted examples of excellent positive behaviour support plans. The collaboration between nursing, OT and psychology staff to produce high-quality person-centred plans was commendable.

Risk assessment and risk management plans were comprehensive and regularly reviewed. We felt that the records we reviewed and the discussions we had with staff, evidenced a positive and thoughtful approach to risk taking across both wards.

We did not see comprehensive evidence of individual and family/carer involvement in care planning and risk assessment in the records reviewed, however we did hear from staff about their discussions with family/carers and the sharing of draft copies of plans to actively seek their views.

Some records we reviewed noted that individuals could not participate in creating their care plans because they lacked the capacity to do so. We did see that staff continually sought feedback from people when they were delivering care and support, by observing behaviours and attending to what was communicated verbally.

There were examples of communication aids being used. For example, one person had a lanyard with green on one side and red on the other to enable them to communicate to staff when they wanted to start or stop an activity. It was evident that obtaining feedback from individuals on the care and support being delivered was important in both wards.

Care records

Care records were held electronically on the TRAKCare system. We found this straightforward to navigate.

Care plans and risk assessments that we reviewed were detailed, clear and holistic; descriptive interventions linked well to identified needs and goals.

Continuation notes were informative and linked well to individuals' care plans. The language used was person-centred and trauma informed.

We saw comprehensive mental state and physical health reviews by the consultant psychiatrist and other medical staff. It was apparent from the records we reviewed that there was a full range of professionals contributing to care and treatment for individuals including nursing, medical, OT, physiotherapy, pharmacy, speech and language therapy, dietetics and social work.

Multidisciplinary team (MDT)

Both wards had comprehensive input from a range of multidisciplinary professionals to ensure that holistic needs and risks were met.

One full time consultant psychiatrist covered both wards, supported by two medical staff in training. It was positive to hear that an additional speciality doctor was soon due to join the service.

We heard that psychology staff were very involved and a valued part of the team in both wards. Their skilled input was evident through care plans and risk assessment/management documentation.

We heard that OT staff were an integral and active part of the team, informing and delivering the complex care plans required for individuals. We were concerned to hear that two OT posts had been lost in recent months and that these may not be replaced due to budget constraints. Inadequate OT input for such complex individuals could lead to extended stays in hospital and could impact negatively on successful discharge to community settings. We would support the request recently

submitted by the lead OT, to senior managers to resource OT staffing at an adequate level.

Recommendation 1:
The occupational therapy service should be resourced adequately for the complex group of individuals in Strathbeg and Loirston wards, given their significant role in formulating and delivering evidence-based care plans in partnership with nursing staff and the wider MDT.

MDT meetings took place weekly and records evidenced that a full range of professionals attended. Meeting records generally provided a detailed summary of individual progress and noted the decisions and actions required.

All individuals in Strathbeg Ward were managed using the care programme approach (CPA) which provides a robust framework for managing care and risk. We noted that individuals and family/carers attended their CPA meetings regularly, but this was not so evident relating to the weekly MDTs. We did hear that the consultant psychiatrist and nursing staff met with people either before or after the MDT meeting to review and provide an update.

We heard that there continued to be a relatively high proportion of individuals in both wards identified as being delayed discharges, with four out of the five individuals in Loirston and three people in Strathbeg considered to have their discharges as delayed. Issues related to challenges with identifying suitable property, adaptations that were required and recruitment of staff to provide individualised 24/7 support packages.

We heard that some individuals had experienced multiple placements breaking down in the community. The SCNs advised that one particular health and social care partnership (HSCP) in Grampian had a higher number of admissions of complex individuals following placement breakdown and that there was significant gaps in terms of availability of specialist resources.

This led to challenges for the MDT in working with this HSCP. It was positive to hear from senior managers that this had been recognised and that a Grampian-wide approach to the commissioning of learning disability services was being developed, encompassing the three HSCPs working in partnership. We look forward to hearing how this develops and will link in with senior managers for updates.

Use of mental health and incapacity legislation

All five individuals on Loirston Ward were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) on the day of the visit.

Of the six individuals in Strathbeg, two were detained under the Mental Health Act and four under the Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure

Act). Paperwork relating to detentions was accessible in paper files and held electronically in TRAKCare.

There were welfare guardianship orders in place under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) for 10 out of the 11 individuals on both wards. Copies of orders were available and accessible in paper files, with some stored on TRAKCare. There seemed to be good overall awareness amongst the staff group about the guardianship role and function.

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 across both wards.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of 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 Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

All individuals apart from two had a section 47 certificate in place. We found one certificate was out of date and in another, it was not apparent whether the individual's guardian had been consulted.

It was positive to see that certificates had accompanying treatment plans, but in some cases, there was reference to matters not relevant to section 47, such as, consent to being in hospital.

The Commission has produced a good practice guide relating to treatment under section 47 of the Adults with Incapacity Act and we signposted relevant staff to this on the day of the visit.

Rights and restrictions

All individuals across the two wards were subject to detention under the Mental Health Act or the Criminal Procedure Act. Both wards operated a locked door policy which was appropriate to manage the level of risk that individuals presented with.

There was information about the locked door policy in place at the main door of each ward, including this in pictorial format to aid understanding for the individuals being cared for.

We heard from the advocacy organisation for both wards that they felt welcomed, valued and that they regularly visited the wards. Staff were aware of the advocacy role, and the individuals that we met with who had some understanding of their legal status, knew about their right to advocacy.

The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act which are written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility to promote advance statements. No one on either ward had an advance statement in place; we felt that some individuals would be able to complete one with the right support. We heard that there was some work planned to promote advance statements in partnership with advocacy.

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 person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied.

Five out of six individuals in Strathbeg, and one person in Loirston were subject to specified person legislation, with reasoned opinions in place relating to these restrictions. We noted that not all forms had been completed confirming receipt by hospital managers, or the mandatory notification made to the Commission in all cases. We followed this up with the Mental Health Act administration office in the hospital.

There were individuals in both wards who were nursed on a continuous basis in their own larger area. They had detailed care plans and daily and weekly planners in place, which included regular trips outside of the ward to the hospital grounds or the local community. We were pleased to see one such individual interacting with their daily planner, by ticking each activity off their list when complete. We thought that this afforded them a level of ownership and control with a structured care plan.

We had previously recommended that senior managers devise and implement a policy relating to use of seclusion. We were told that this was still in draft form but would be discussed by senior managers at the next clinical operations group. This should be finalised and implemented as a priority.

Recommendation 2:
Senior managers must finalise and implement the draft seclusion policy as a priority.

Activity and occupation

We heard from staff about the valued joint working between nursing and OT to provide as wide a range of recreational and therapeutic activity as possible for individuals, which was reflected in the weekly activity timetables that were in place.

There had been a recent whole site, large scale recruitment drive where 130 health care support workers (HCSW) had been employed. We were pleased to hear that Loirston and Strathbeg were to get an additional seven and five HCSWs respectively; there was consideration that they would focus some of their time on delivering activities. There was evidence of commitment and creativity of staff focusing on delivering activities, and an appreciation of how integral this was to care plans.

There were rooms set up in both wards for leisure, recreation and therapeutic activity. These were spacious and well equipped with arts and crafts materials, exercise equipment, sensory equipment, TV and gaming consoles, pool table and board games. Several individuals had regular 'sensory sessions' with staff as part of their timetable each day, which involved exercises on mats and trampettes, sensory lights and weighted blankets.

We heard about individuals taking part in groups and activities in the recovery resource centre including breakfast, lunch and supper groups, exercise, café sessions and movie nights. There was a focus on linking individuals to groups and activities in the local community to promote inclusion and work towards discharge planning.

The physical environment

The Commission had noted multiple issues with the physical environment of both wards in the last few years. Issues were in part related to the fact that these wards were designed to accommodate older adults, so did not offer an optimum environment for the management of the behavioural and sensory needs experienced by individuals with learning disability and/or autism.

Issues also stemmed from inadequate investment in the environment. We heard that there was no rolling programme for decoration of the wards, and saw several areas where paintwork was marked, patchy and woodwork was not painted. Much of the space was bland and 'clinical'. Considered use of colour appropriate to individuals' sensory needs would go some way to creating an improved ambience in the wards.

Showering/bathing facilities in both wards remained inadequate; with one shower room and one bathroom in each. We heard that when individuals had to wait to access the bath or the shower, this could lead to stress and distressed behaviours. We noted that in particular, the shower room in Strathbeg Ward needed urgent refurbishment and were assured by the SCN that the required work had been agreed.

We continued, as was the case at the previous visit, to have concerns about the level of privacy and dignity afforded to individuals due to a lack of privacy film on some windows, with some rooms facing out to public paths and curtains missing. We acknowledge that individuals may pull curtains or blinds down and rip privacy film

from windows and that it is an ongoing challenge to ensure that the environment is conducive to promoting maximum privacy and dignity for individuals.

Access to pleasant outside space is important in promoting mental well-being. Loirston Ward is located on the first floor and did not have easy access to a garden, however, there was a significant focus on supporting individuals to get out of the ward for walks in green space. The garden in Strathbeg Ward required improvement, including to remove rubble/boulders which could pose a risk of being thrown.

We heard that staff worked creatively to consider ways of enhancing the environment, for example, decorating the walls with art projects and procuring furniture, televisions, exercise equipment and more from free or low-cost online exchange/recycling sites. We heard about staff using their own funds to acquire items for the wards and while this speaks to their care and commitment, it should not be necessary.

We were pleased to hear about the creation of a sensory room in Loirston Ward, which had been possible due to a grant received from the NHS Grampian Charity. We saw that this was well used by individuals throughout the day of the visit.

We had previously recommended that full environmental assessments be carried out in both wards and a plan of improvements made and were pleased to hear that these assessments had been completed. However, SCNs were not aware of a plan or timeline being agreed for any improvement work.

The SCNs and other staff had set up a working group to consider what smaller improvements could be made to the environment in the meantime. We thought that this was to be commended, nevertheless, senior managers should set out a comprehensive plan for improvement of the physical environment, informed by the assessments which had been completed as soon as possible.

Recommendation 3:
Senior managers must ensure that the environmental assessments completed for both wards inform a comprehensive improvement plan, which includes clear timeframes for completion.

Summary of recommendations

Recommendation 1:

The occupational therapy service should be resourced adequately for the complex group of individuals in Strathbeg and Loirston wards, given their significant role in formulating and delivering evidence-based care plans in partnership with nursing staff and the wider MDT.

Recommendation 2:

Senior managers must finalise and implement the draft seclusion policy as a priority.

Recommendation 3:

Senior managers must ensure that the environmental assessments completed for both wards inform a comprehensive improvement plan, which includes clear timeframes for completion

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.

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