

**Mental Welfare Commission for Scotland**

**Report on unannounced visit to IPCU and announced visit  
to the Forensic Acute and Rehabilitation Unit:**

Blair Unit, Royal Cornhill Hospital, 26 Cornhill Road, Aberdeen,  
AB25 2ZH

**Date of visit:** 8 and 17 August 2017

## **Where we visited**

The Blair Unit consists of the IPCU, Forensic Acute and Forensic Rehabilitation Unit. We last visited this service on 20 September 2016 and 17 November 2016 making the following recommendations: the need to provide consistency and chronology in care plan records; the requirement that mental health act forms are up to date and accessible; the need to promote smoke cessation over providing escorts for smoking; review of the removal of furnishings from the garden area; a record should be kept of participation in activities.

On the two days 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 12 patients.

We spoke with the charge nurse and other clinical staff.

## **Commission visitors**

Douglas Seath, Nursing Officer

Kate Fearnley, Executive Director (Engagement & Participation)

Margaret Christie, Social Work Officer

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

Unusually, all the patients in the IPCU at the time of the visit were female, four admitted following forensic mental health detention. Some of the individuals were very unwell including one patient being nursed in her bedroom with minimal furniture and on increased observation level. This was proving to be fairly challenging for the staff in terms of the level of clinical activity and the additional requirements of the nursing resource. We noted and discussed with staff on the day a lack of care plan in place to deal with the stressed and distressed behaviour.

The situation brought to light the contrast between the needs of civil and forensic patients and the difficulties in having this particular mix in one ward. Patients with a forensic history can be stable in mental health and tend to stay for long periods requiring rehabilitation, whilst civil patients are only admitted during acute periods of stress and distress.

Risk assessment and management plans were in place throughout the Blair Unit for all patients and care and recovery plans were detailed and subject to review in most cases. Multi-Disciplinary meetings were well documented and attendance of those present almost always listed in the files. A record of 1:1 sessions between named nurse and individual patients was also present. There was a range of styles of care plans in use. Nevertheless, these were well ordered and easy to find in the patient file.

We were informed that the service is moving to a new style of care plan in a pre-formatted booklet, which should help to address this discrepancy.

We were particularly pleased to hear that patients were positive about the support they received from staff in the wards Psychological therapies, physiotherapy, occupational therapy also provided regular input.

### **Recommendation 1:**

Managers should consider how the needs of civil and forensic female patients with quite disparate needs and backgrounds can best be met in the in-patient setting.

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

Notes were not consistently organised and so it was not always easy to determine where Mental Health Act paperwork was located. Consent to treatment forms, though completed, were not always located with the medicine kardex where they should be.

We found that some Mental health Act suspension of detention forms were out of date. This could lead to patients being formally 'absent without leave'.

Additionally, several Mental Health Act specified person forms were either missing or out of date which could have led to patients having restrictions placed without due legal authority.

### **Recommendation 2:**

Managers should set up regular audit of Mental Health Act paperwork to ensure forms are present and up to date.

### **Rights and restrictions**

One patient raised a concern about his ability to access the external grounds in order to smoke. However, he has been offered smoke cessation help and nicotine substitutes.

### **Activity and occupation**

There was good activity provision, and individuals were involved in a range of those both within and outwith the ward including: cooking; breakfast group; gym; college attendance; swimming; catering; music lessons; picture framing; badminton; Reach Out service; walking group; gardening; work placements; and visits to shops or to the libraries.

Each patient within the forensic service had activity plans in keeping with the need for rehabilitation, where appropriate.

## **The physical environment**

Furniture previously removed from the garden for reasons of security in the forensic unit has been replaced. The garden is now pleasant and well maintained and patients were observed using it. The external door is usually unlocked but currently locked due to one patient's needs. Staff were observed opening it for patient use on request.

The decoration and furnishings were generally rather tired. The poor layout of the ward also restricts observation.

Refurbished shower rooms were not ligature free. However the Senior Charge Nurse has pointed this out to managers and this is being rectified as part of a review of safety measures being undertaken throughout the wards.

The single room in the forensic ward, previously out of use, has been refurbished with the aim of making it safer and less able to be damaged. The heating is located in ceiling panels and the electricity supply can be switched off from the office if the patient is at risk.

## **Any other comments**

There have been major difficulties recruiting registered and healthcare support workers and also medical staff. The forensic acute ward was closed to admissions on the day of the visit due to clinical activity and a combination of staff vacancies maternity leave and long term sick leave (at 60% of normal wte staffing, but with regular bank nurses to help supplement the staffing numbers on the 17<sup>th</sup>). Additional nursing staff have been appointed to commence in September 2017 which should ease the need for use of bank staff.

The staff anticipate difficulties from 1 October 2017 when no smoking will be allowed in the hospital grounds. Patients are provided with nicotine replacement therapy and inhalers. Staff have also been in communication with Rohallion Medium Secure Unit about possible use of 'secure e-cigarettes' in future. Patients currently can only smoke on escorted pass outwith the hospital building.

## **Summary of recommendations**

### **Recommendation 1:**

Managers should consider how the needs of civil and forensic female patients with quite disparate needs and backgrounds can best be met in the in-patient setting.

### **Recommendation 2:**

Managers should set up regular audit of Mental Health Act paperwork to ensure forms are present and up to date.

## **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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