Mental Welfare Commission for Scotland

Report on unannounced visit to:
Forensic acute and Forensic Rehabilitation wards, Blair Unit, Royal Cornhill Hospital, Cornhill Road Aberdeen, AB25 2ZH

Date of visit: 23 and 24 September 2024

Where we visited

The Blair Unit is based in the Royal Cornhill Hospital and comprises of an intensive psychiatric care unit (IPCU), a low-secure forensic acute ward, and a forensic rehabilitation ward.

The forensic acute ward is an eight-bedded unit that provides a low-secure care for males; the forensic rehabilitation ward is also a low secure setting, with 16 beds for male patients.

On the day of our visit, there were eight individuals in the forensic acute ward and 18 individuals in the rehabilitation ward. We were told that the rehabilitation ward had continued to use two surge beds, since our last visit.

We last visited the IPCU on 20 August 2024.

We were told that individuals were transferred to the rehabilitation ward from the acute ward once their mental health has stabilised and they are able to participate in the next stage of their recovery. We last visited this service in November 2023 on an announced visit and made recommendations regarding authorisation of treatment, specified person legislation and the environment. The response we received from the service was detailed in an action plan, informing us as how the service planned to meet those recommendations.

On the day of this visit, we wanted to follow up on the previous recommendations, including those that recommended the service improve the environment for individuals.

Who we met with

In the acute ward, we met with four people and reviewed their care records.

In the rehabilitation ward we met with three people and reviewed their care records. We also reviewed the care records of a further three people, who we did not meet in person.

We spoke with the senior charge nurses (SCNs), the nurse manager and two consultant forensic psychiatrists. We also spoke with ward-based staff, including the activity nurse.

We also met with the local advocacy service, which was based in the hospital.

Commission visitors

Tracey Ferguson, social work officer

Graham Morgan, engagement and participation officer

Anne Buchanan, nursing officer

Lee Whittaker, student nurse

Dr Juliet Brock, medical officer

What people told us and what we found

The SCNs told us that the staff continued to work across the Blair Unit and that this reviewed at the daily manager's meeting; changes to staff deployment depended on the clinical demand in each ward. This daily meeting also discussed admissions and discharges across the unit, as well as the staffing numbers required to ensure safe delivery of individual care. Staff told us that by working across the Blair Unit, this provided them with the opportunity and experience to work with individuals, throughout different stages of their recovery journey.

The SCNs told us about continued proactive efforts to recruit staff to vacancies and it was positive to hear that they had recently recruited to posts through the new graduate recruitment scheme. We were told that the current vacancies had arisen from staff moving to other posts in the forensic services, which was similar to what we were told on last year's visit, although it was positive to hear that many staff had remained with the service.

Individuals in the acute ward required more intensive assessment and support due to the acute phase of their mental ill health, and we found this to be the case on the day of the visit. For individuals in the rehabilitation ward, they were actively working on their rehabilitation plans and spent more of their time out in the community. We were told that some individuals were actively planning for discharge, and we heard about the plans in place to support people moving onto their next stage of their journey. We were also told that there may be occasions when an individual required to be transferred to another ward in the Blair Unit due to a change in their mental state; in these circumstances, discussions tended to take place at the daily huddle or sooner, depending on specific concerns and risk.

Feedback from individuals about staff in the forensic acute ward was mostly positive. Individuals described staff as "approachable" and "helpful" and a few told us that the staffing team dealt with issues on the ward quickly, particularly when an individual may be at risk due to their mental state. We heard from one person that we spoke with that they felt "safe" on the ward, while another told us that they felt involved in the decision-making about their care and treatment and that their views were considered by all involved professionals. One individual told us this was "the first time anyone had sat down and discussed my diagnosis with me and provided me with decider skills, which helped me". We gained a sense from speaking to staff and individuals that they worked together in supporting positive relationships with the families, as in some cases, individuals had transferred from prison and family relationships had become fractured.

Some individuals told us about the activities that they enjoyed with the activity nurse and the occupational therapist (OT). However, we heard from one individual that they were often "bored".

Feedback from individuals in the rehabilitation ward was mixed. Some that we spoke with described the ward as “boring”, that “some wards were better than others” and that it was “not a good environment”. One individual told us that the “doctors don’t listen” but the “food was great”. Others described the staff as “good” and “approachable” and told us that the staff team sorted out situations quickly. One person told us that they “would prefer quieter areas” while others told us that they met with their doctor and psychologist regularly.

We spoke to a few individuals who told us about their plans for discharge and we heard that they felt involved in the planning of this. One individual described the support from advocacy as “good”. Another told us that they “would like to do more cooking” and that they “had a great doctor”. A few people told us that they would like their own room as they didn’t like sharing. We heard from others that there was “lots of activities to do” but they felt that the community meetings were not really helpful.

We spoke with the local advocacy service and they told us that advocates continued to be invited to meetings and that managers were keen to hear feedback on the service. An advocate told us that mental health officers (MHOs) would frequently refer individuals for advocacy support and that the advocates would support people with completing advance statements.

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 looking to improve care planning documentation and processes. This documentation was just being rolled out on our visit last year and on this visit, we were pleased to see the care planning documentation in place.

We found that most care plans were detailed, person-centred and identified goals, along with detailed interventions to meet these goals. We did find some care plans in the rehabilitation ward that lacked specific detail regarding the individual rehabilitation goals; we discussed these with the SCN on the day of our visit.

We saw that care plans were being regularly reviewed, but across both wards, some reviews lacked detail. We found that the ‘review’ often simply stated “remains relevant”. We provided feedback to managers about one individual in the rehabilitation ward where their passes out of the ward had been stopped and although this was recorded on the review section of the care plan, there was no specific detail regarding the reason for this change.

Recommendation 1:
Managers must ensure that there is a robust care planning audit system in place that ensures care plans reviews are detailed and where audits have been completed, that all actions are addressed.

We found that participation in the care planning process had improved, and some individuals had either signed their care plans, had a copy of the document, or told us about the process and of the goals they were working towards. Where some had not been signed, there was a reason for this recorded on the document. Our view would be that individual care plans should be discussed and shared, if appropriate, at various stages in the individual's journey, enhancing their involvement. We found the care planning in the acute ward evidenced a good balance of individual safety and security along with psychological interventions.

On reviewing a file in the rehabilitation ward there was a copy of a recent audit placed in the file. We saw that audits had been completed in July and September however, it was disappointing to see that although the auditor had made recommendations for improvement and that these had not been actioned.

The SCN told us that the new audit tool had been devised as part of the improvement plan and that audit has been carried out across the other wards in the hospital. We were pleased to see this new documentation in the wards, along with the regular audits that were being carried out, although we were concerned that the lack of meaningful care plan reviews had not been picked up during the audits. We discussed this further with the nurse manager and SCNs, who agreed to provide us with a copy of the most recent audit outcomes.

We found detailed daily entries recorded by nursing staff in the electronic system. These were relevant, meaningful and provided detailed updates of progress on the care and treatment of the individual, as well as incorporating the individual's views.

We were able to see where a person required 'as required' medication, the reason why this was needed, along with interventions that were used prior to use of medication.

Across both wards, we saw recordings of frequent one-to-one meetings between the nursing staff and individuals, as well as regular meetings between individuals and their responsible medical officer (RMO). All multi-disciplinary staff now use the electronic recording system for daily recording and we felt that this was an area that had improved as all records and updates about patient care were now being recorded in one place.

In terms of risk assessments and risk management plans, we found a rapid risk assessment in each of the care records we reviewed, and risk information included in care plans. We noted that HCR-20 risk assessments had been updated by the forensic psychologist. Given the service is in an interim period between paper and electronic files, we suggested that 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 the unit and all other wards in the hospital were implementing new risk assessment and risk management documentation, and that the assessment and care planning booklet that was previously in place was no longer being used by some wards. Both forensic wards were still using this booklet until the new documentation was ready to be implemented on the electronic system.

The Commission has published a good practice guide on care plans[1]. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

Care records

Managers told us that some documentation had recently been transferred to the electronic system TRAKCare, which has been rolled out across NHS Grampian. We accessed individual electronic records, as well as paper files that were still in place.

The SCN told us that the plan for the unit was to eventually have all recording and documents transferred over to the electronic system. We were told that the ward-based staff and multidisciplinary team (MDT) recorded all daily contact with individuals on this system and that the weekly MDT meetings were also being recorded on TRAK.

Multidisciplinary team (MDT)

There are three consultant forensic psychiatrists and two clinical psychologists who cover the Blair Unit. We heard that occupational therapy (OT) provision had increased since our last visit and that the unit now had two OTs and one OT assistant. The MDT meeting continues to take place weekly. We were told that this meeting was attended by all the professionals, including social work or social work mental health officers (MHOs), when necessary. The wards had regular pharmacy input, and we were pleased to note that following a recommendation from our last visit, routine audits of Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) treatment certificates that took place across the hospital.

The electronic MDT meeting record provided a detailed overview and update of each individual's care and treatment, along with a record of who attended the meeting and any outcomes or actions. We found the new electronic recording format to be robust and it covered all necessary aspects of a person's care and treatment, including 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 and the forensic consultants also met with individuals before or after the meeting. From our

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

review of the care records, we saw evidence of this, along with the individual's views being sought and recorded. The new format has enabled prompts that help with the review of treatment. Staff told us that they were getting used to this new recording format, which they thought was much needed, and they felt there had been an improvement in a short space of time. The leadership team told us that there were some areas where further improvements were needed with the electronic system. We were pleased to hear that the staff had adapted well to the new system and with the detailed level of recording.

Several individuals in the rehabilitation ward were subject to Multi Agency Public Protection Arrangements (MAPPA) and the Care Programme Approach (CPA). CPA is a framework used to plan and co-ordinate mental health care and treatment, with a particular focus on planning the provision of care and treatment through the involvement of a range of different professions and by keeping the individual and their recovery at the centre.

We were told that the ward had a programme of dates set for these meetings which tended to be on a six-monthly basis, or sooner, depending on individual circumstances. We were pleased to see evidence of individual participation, along with support from advocacy. The minutes of the CPA meetings were detailed and thorough, covering all aspects of the individuals care and treatment.

We wanted to follow up on the progress of discharge plans for two individuals in the rehabilitation ward. We were aware from our last visit that due to the complexity of their care and support that they required, finding community placements had been difficult. We were pleased to hear that accommodation had been sourced for both and that other aspects of the discharge plans were coming to fruition; we will continue to request an update from the SCN with regards to this.

Use of mental health and incapacity legislation

On the day of the visit all individuals across both wards were detained under the Mental Health Act, or the Criminal Procedure (Scotland) Act 1995 (Criminal Procedure Act). We found that the detention paperwork was in order and easy to find in the paper record.

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 each individual's files and were easily accessible.

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. We found two issues with consent to treatment certificates (T2) across the wards and we found an issue with one individual's

certificate authorising treatment (T3) under the Mental Health Act in the rehabilitation ward. We followed these issues up post-visit and we were satisfied with the information we received regarding treatment. From our visit last year, robust measures had been put in place by the service to address treatment and we noted there to be an improvement. We are aware that there had been ongoing audits by pharmacy across the whole hospital and that pharmacy had devised good practice guidance for all staff.

With the service now recording the MDT meeting on TRAK, this provides a prompt for discussion regarding treatment certificates that should help ensure treatment is legally authorised and individual rights are safeguarded.

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 this in the care record.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act 2000 (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.

There was only one individual in the rehabilitation ward that had a section 47 certificate in place; we found this in their paper file. We discussed the s47 further with the consultant forensic psychiatrist as the certificate lacked detail and there was no treatment plan attached. The certificate had been completed by a previous GP for the unit. This individual had a T2 certificate in place and was consenting (and was deemed capable to consent) to treatment under part 16 of the Mental Health Act. It was unclear what physical healthcare medical treatment was being provided for this person, as it was not listed. The RMO agreed to urgently review this.

The consultant psychiatrist told us that the ward did not currently have any input from a GP and had not done for some time, but that the service was looking to address this. If someone required to be assessed and forms completed with regards to Mental Health Act or AWI Act, this would fall to the RMO to complete. We also discussed the same individual's capacity regarding finances, as there was an expired certificate in the file. Fortunately, the hospital patient funds manager had a current 'incapax' certificate which has now been placed in the individual's care record.

Rights and restrictions

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

We found specified person paperwork and the reasoned opinion to be in order in the acute ward, however, we had a further discussion with SCN about two individuals' specified person status in the rehabilitation ward. We were told that one individual was specified for safety and security however, the RES1 that was in the file had expired. The other individual had recently been admitted to the ward and there was no specified paperwork in the file however, the staff told us that he would need to be specified, as everyone has to be, as per unit policy. We also saw it recorded in individual care plans that the individual required to be specified because of the Blair Unit policy.

We are aware that in some areas, admission to a low-secure (forensic) ward incorrectly results in almost automatic designation as a specified person. This practice is not supported by the Commission and is not compatible with the principles of the Act, nor with each person's human rights. All low-secure facilities, IPCUs, and acute admission wards should make decisions about specifying people and implementing these regulations on an individual basis and only if and when the RMO has recorded a reasoned opinion that sets out the risk to the individual or to others should these restrictions be put in place.

We discussed this further with senior nursing staff and RMOs who told us that each person was individually assessed and that this was not automatic practice across the wards. However, this was not reflected in some of the discussions we had with other members of staff, or what was recorded in the care records, and it was clear there was confusion amongst the staff about specified person status and the low secure unit policy with regards to restrictions. We suggest that the policy is amended to reflect the Commission's guidance.

Recommendation 2:
Managers should consider delivering training across the MDT to support and enhance staff understanding in the application and use of specified person legislation.

The Commission has produced good practice guidance on specified persons[2].

From speaking to individuals in the acute ward we were aware that some individuals could not advise us of their legal status, but this may have been due to the stage in their recovery. We found paperwork in individual files and care plans that covered this detail, so there was evidence that individuals had been provided the information.

[2] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512

We therefore suggested to the SCN that perhaps their legal status, including their rights should be revisited at periods throughout their admission.

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 and we found where a person had made one, there was a copy in the care record. In terms of promoting these, we suggested for the service to consider input from advocacy at one of the wards community meetings.

The wards had good links with the local advocacy service, and we saw evidence of individuals meeting with their advocate, being supported during meetings and supported with their rights.

The Commission has developed *Rights in Mind.*[3] 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 wards. One activity nurse mainly provided input to the IPCU and the other to the acute and rehabilitation wards.

We met with the activity nurse and heard how their role enhanced the delivery of therapeutic provision to individuals, aiding in their recovery. We were told that where appropriate, activities could be on a one-to-one basis or in groups. 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.

The activity nurse told us that they worked closely with OT as part of discharge planning and when supporting community activities. When a person is first admitted, they would meet with the activity nurse and thereafter on a weekly basis, to try to find out what activities they enjoyed. As some individuals had ongoing support from care providers, the activity nurse tended to work with other individuals who did not have this type of support. A weekly planner for the two wards was developed, and we saw the activity planner for that specific week. The planner included outdoor activities such as walking group, cinema and playing pool at the local pool hall. Other activities included board games, gym, chess and baking.

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

The service had a gym that was situated in the rehabilitation ward and individuals in the unit had access to this after discussion and agreement with their RMO and the physiotherapist.

The unit had access to OT provision and individuals were able to tell us of the activities they participated in, on and off the ward and of the benefit they got from the available activities. We found evidence of this recorded in files of the individuals that we reviewed, along with the activity that had been 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. We heard from staff that OT provision had increased since our last visit, due to successful recruitment. We were told that OT would undertake assessments as part of discharge planning and that these included functional and environmental assessments.

We felt that the wards had a high level of activity provision, however, we were aware that activities provided by the activity nurse mainly took place Monday to Friday. We therefore feel that the service needs to consider the flexibility of this role to ensure activities are available at weekends, as this was when some individuals told us that they were bored.

The physical environment

In our last four visits, we have continued to make the same recommendations in relation to the accommodation and the environment. We were disappointed and concerned to see that once again, there had been no significant improvements made to the accommodation since our last visit.

The wards had a mixture of single room and dormitory style accommodation. 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 no fresh air was afforded into the ward.

The acute ward had one communal area in which individuals ate their meals, watched television and carried out activities. The rehabilitation ward had a lounge area, activity room, kitchen and gym. There was a separate smaller kitchen where individuals were able to make a hot drink throughout the day and evening.

Both wards had access to a garden area however, there continued to be lack of interview space and quiet areas for individuals. Bathrooms across both wards were in need of an upgrade. The flooring in the communal areas across both wards had been replaced, which made these areas brighter.

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. The report made specific recommendations regarding the physical environment of forensic services and for health boards to address these issues.

We have continued to raise our concerns with senior managers in NHS Grampian and the Scottish Government and as yet, nothing had changed.

We are aware of 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, following on from the concerns raised by the 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 advised us that a scoping exercise was being undertaken regarding essential works and that a forensic services accommodation project board had been set up to lead and oversee the improvement work. We have since been updated by senior managers that a budget spend of £1 million has been approved for this financial year in order to commence the upgrade of works that are required across the Blair Unit, in line with the Barron Report.

We concur with the views of the Barron Report, in that individuals who require to be admitted to a forensic unit 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 updates on the Blair Unit accommodation from NHS Grampian senior managers.

Recommendation 3:
Senior managers must progress the work of the forensic services accommodation project board to ensure that the Blair Unit environment is safe, welcoming, therapeutic, and fit for purpose.

Summary of recommendations

Recommendation 1:
Managers must ensure that there is a robust care planning audit system in place that ensures care plans reviews are detailed and where audits have been completed, that all actions are addressed.

Recommendation 2:
Managers should consider delivering training across the MDT to support and enhance staff understanding in the application and use of specified person legislation.

Recommendation 3:
Senior managers must progress the work of the forensic services accommodation project board to ensure that the Blair Unit 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.

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