mental welfare
commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to:
Royal Cornhill Hospital, Forensic Acute and Rehabilitation Wards, Blair Unit, Cornhill Road, Aberdeen, AB25 2ZH

Date of visit: 17 February 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

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

The Blair Unit is currently undergoing refurbishment work to address concerns raised about the environment in line with the Independent Review of Forensic Mental Health Services 2021 (the Barron Report) and reduce the infrastructure risk profile. This work was ongoing at the time of our visit; to facilitate the work, the acute ward had moved into an area of the rehabilitation ward and beds had been reduced to reflect the smaller environment.

The forensic acute ward is a six-bedded unit (reduced from eight during the refurbishment) that provides low-secure care for males; the forensic rehabilitation ward is also a low-secure setting, with 15 beds (reduced from 16 during the refurbishment) for male patients. 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 the forensic community team or the intensive psychiatric care unit.

On the day of our visit, there were six individuals in the forensic acute ward and 15 individuals in the forensic rehabilitation ward.

We last visited this service in September 2024 on an unannounced visit and made recommendations on care planning, 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, meet with individuals receiving care and treatment, speak with staff, and hear about the impact and progress of the refurbishment works.

Who we met with

We met with 14 people, seven of whom we also reviewed their care records. We also reviewed the care records of three others and spoke with a relative.

We spoke with the service manager, the senior charge nurses (SCNs), the lead nurse and the three consultant psychiatrists.

In addition, we contacted and received feedback from local advocacy services for Aberdeen City and Aberdeenshire.

Commission visitors

Susan Hynes, nursing officer

John Crichton, executive director (medical)

Audrey Graham, social work officer

Kathleen Liddel. social work officer

Graham Morgan, engagement & participation officer

Inez Kohls, student nurse

What people told us and what we found

We were told that staff worked across the Blair Unit, depending on the clinical demands of each ward, which were reviewed at the manager's daily huddle meeting. Staff told us that this model of working provided them with the opportunity and experience in working with individuals throughout different stages of their journey, across the whole service.

We also heard how the ongoing refurbishment work was felt to have enhanced a collaborative way of working between the wards. There was consideration at the daily huddle of individuals' environmental needs, with moves between wards accommodated to meet these needs.

Managers told us there had been a recent staffing review which showed a requirement for an additional 10 health care support workers in the acute ward and seven in the rehabilitation ward. 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.

The SCNs told us that individuals were at various stages in their recovery journey, with some spending longer periods in hospital, and others who have had a more recent admission or transfer between the forensic services.

The individuals we met with in the acute ward required more intensive assessment and support due to the acuity of their mental health symptoms and two were on continuous intervention. They told us they found the staff "great" and "friendly"; they said to us that although they didn't agree with aspects of their treatment, staff made it easier. One person had been restrained on several occasions. He told us he felt this had been done in his best interests and felt that staff were compassionate and thoughtful about this intervention.

Some people we met with in the acute ward reported it could be boring and felt there were limited activities to do on the ward, while others felt there was plenty to do.

Individuals in the rehabilitation ward were actively working on their rehabilitation plans, regaining independent skills and were more engaged in community activities. People we met with in this ward described staff as "good", "thoughtful" and "sound", although they described them as overworked and too busy at times to be able to respond in a timely manner. The individuals described engaging in a good range of activities and appreciated the links with further education and community services. We were told that where individuals had escorted time out of the wards, staff ensured this happened, with it only occasionally needing to be cancelled.

The people we met with in both wards reported their doctors were good and would listen to them, although some voiced frustration that they did not agree with the decisions that were made. Individuals in both wards reported receiving regular

one-to-one meetings with nursing staff and weekly meetings with their doctors. Some felt this was adequate, whereas others would have liked more regular meetings and inclusion in the weekly multidisciplinary team (MDT) meeting; they did acknowledge that they received prompt feedback from this meeting.

We were told there was good access to psychology and occupational therapy (OT) in both wards, which individuals found beneficial.

We were keen to hear about any impact of the acute ward moving into part of the rehabilitation ward during the Blair Unit refurbishment. All the individuals and staff we spoke with understood why the move was necessary 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 supported this. Most of the individuals we spoke to described being negatively impacted by the move, with the ward being cramped and the reduction of communal space being the main complaint. One person described the gym area in the rehabilitation ward being smaller and lacking ventilation. Several people complained about the dormitory accommodation lacking privacy, being noisy, and feeling unsafe if someone became distressed.

We discussed this with managers on the day, who had attempted to mitigate the adverse effects of the smaller environment in various ways, such as supporting more access to offsite occupational provision, moving individuals with increased care needs to the intensive psychiatric care unit, and regular feedback meetings which were supported by collective advocacy. We will continue to follow this up with the service.

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.

Staff told us that the transition had gone well but the service was aware that there remained work to do with the transition to electronic care planning. Care plans were also held in paper format, along with some assessment documents and legal paperwork.

We were told that all the ward-based staff and the forensic consultant psychiatrists recorded their daily contact with individuals on the system and the weekly MDT meetings were also being recorded on TRAKCare. We found the system easy to navigate but found there was an inconsistent approach to the format of the recorded information. In the rehabilitation ward we found some paper records which held significant amounts of historic information and in some instances, paper care plans and electronic care plans held different information for the same person. We were

concerned this could cause confusion and important information could be overlooked. We discussed this with managers and understand that the service is in the process of moving to a fully electronic system.

Care plans we reviewed in the rehabilitation ward were inconsistent. Some were well structured with plans identifying needs, agreed goals and the required interventions to meet these goals. We reviewed others that lacked detailed information about the specific interventions required to meet identified need and did not contain a regular review or identify progress towards goals.

The care plans we reviewed in the acute ward contained more detail about interventions that would support the individual achieve the identified goal. These had been reviewed regularly and although brief, they contained relevant information.

In both wards, we felt some care plans could be more person-centred. There was limited evidence in the records that we reviewed of individual involvement in the care planning process; for example, with it being 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 better reflected in electronic care plans.

Recommendation 1:
Managers should review their audit processes that are currently in place to improve the consistency and quality of care plans, to ensure that evaluations of care plans clearly indicate the effectiveness of the interventions being carried out, and any required changes to meet care goals. Care plans should clearly evidence individual participation.

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.

In both wards we found detailed daily entries by the nursing team that were relevant, meaningful, and provided an update on the level of progress of the individual's care and treatment, where their views were incorporated. We found evidence of regular one-to-one meetings between individuals and nursing and medical staff, as well as other members of the MDT. There were details of interventions that had been undertaken and reviews for these; this evidenced the detail of care being provided. We would hope to see this reflected in all individuals' care plans at our next visit.

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

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

In the acute ward, some individuals did not have a full risk assessment or a comprehensive risk management plan. In both wards, some of the identified risks had not been care planned for.

While risk assessments identify risks, they are insufficient on their own without a clear, co-ordinated plan that translates 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. 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.

Recommendation 2:
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 individual's needs.

Multidisciplinary team (MDT)
The MDT consisted of OT, psychology, pharmacy, nursing, and medical staff. Other disciplines such as physiotherapy, dietetics, and speech and language therapy could be accessed depending on need. We saw evidence of this involvement in people's notes and how their input had helped positively influence the care and treatment provided.

There were three consultant forensic psychiatrists who covered the forensic acute and rehabilitation wards and who had responsibility for determining admissions there. We heard they also held responsibility for forensic community services; this was felt to support effective transitions between the wards and the community.

The electronic MDT records we reviewed in both wards provided a detailed overview and update of the individuals' care and treatment and recorded who attended the meeting, along with outcomes and actions. We felt there could have been additional detail from the discussion that took place in the meeting that could then have been added to the meeting summary, to describe how decisions were reached.

We were told that individuals in both wards did not attend the weekly MDT meeting, however, the nursing staff met with individuals to discuss any requests before the meeting took place. From our review of the care records, we saw this to be the case

and the forensic consultant psychiatrists also met with individuals before or after the meeting.

Some individuals we spoke to advised us that they would like to attend their weekly MDT and be more involved in discussions about their care. Those who were open to the care programme approach (CPA) told us they attended these review meetings, as did their relatives, where appropriate. CPA is a framework used to plan and co-ordinate mental health care and treatment and involves a range of different people, with a focus on individual involvement and recovery. It is designed to ensure multi-agency collaboration, assessment of needs and planning of care. Individuals and relatives we spoke to who had attended their CPA meeting found these helpful and appreciated the opportunity to be involved in discussions about care.

Use of mental health and incapacity legislation

On the day of the visit, all six people in the acute ward and 14 people in the rehabilitation ward were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure Act). One person had been admitted informally to the rehabilitation ward.

People we spoke with had a good understanding of the legislation they were being treated under and had received written and verbal information. There was evidence of discussions about rights and legal status in the care records and people were aware of their rights around appeal. The person who was admitted informally was clear about his legal status and told us they had chosen to be admitted to the Blair Unit as they knew the staff there and were open to the community forensic team. The person felt the links between the teams would help with their transition into and out of hospital. They were able to come and go freely from the unit, had agreed to the restrictions that were in place, and their care plan reflected their informal status. It was noted the individual was subject to a community compulsory treatment order, but the legal paperwork was not held in the ward records as we would have expected.

All other documentation relating to the Mental Health Act and the Criminal Procedure Act, including certificates around capacity to consent to treatment were available. Some were in paper copy while others were held on the electronic system.

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 available for nursing staff when dispensing medication. We found these corresponded to the medication being prescribed in all but one case in the rehabilitation ward. In this case, a medication had been started before a second

opinion visit had been carried out to authorise a new T3 certificate. We were pleased to see this error had been quickly identified during an authority to treat audit and the individual involved notified and given advice about their legal rights.

Anybody 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 had been nominated, we found details in care records.

Rights and restrictions

All individuals in the Blair Unit 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 right of appeal.

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

Two individuals were on continuous interventions in the acute ward. Staff told us there that there was a review process in place, and we found this documented in their care plans. These had been reviewed and discussed at the MDT meeting and the decision recorded. There were care plans for both individuals detailing the person-centred interventions that were required to support them, the review process and goals explaining the steps required to reduce the level of intervention. During our visit we saw skilled and compassionate interventions from staff carrying out continuous intervention and heard from both people how this helped them in their recovery.

The time out of the ward for individuals in both wards was reviewed at the weekly MDT meeting and recorded in their care records. When 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 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.

We were keen to hear from staff how the recommendation from last year's visit that there should be consideration of training across the MDT to support and enhance staff understanding in the application and use of specified person legislation. We were told that this work had been ongoing and that a protocol was under development by the Blair Unit policies and procedures working group to ensure all restrictions placed on people are lawful and to ensure staff's understanding of the process required. 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. In the acute ward we reviewed an individual where we found that their care records required more specific detail about the type of item that was specified and the risk it posed to justify its removal. This was discussed with the individual's consultant psychiatrist who agreed to follow this up. The Commission has produced good practice guidance on specified persons[2].

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 in the rehabilitation ward; we did not find any copies on file in the acute ward.

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

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 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 the records we reviewed. Staff told us that all individuals had access to OT and that their input towards recovery was invaluable.

We were told that OT undertook assessments as part of discharge planning and that these included functional and environmental assessments.

Last year we noted that activities provided by the activity nurse mainly took place Monday to Friday and had asked the service to consider the flexibility of this role to ensure activities were available at weekends, as this was when some individuals told us that they were bored. We were pleased to hear that an increase in staffing in both wards was expected to support the delivery of an activity programme throughout the week.

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[2] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512
[3] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

We were also told about a new community psychiatric nurse (CPN) post that had been developed in the forensic outreach team. The CPN attended the MDT meetings and worked with individuals to link with community activities and groups; these activities could occur in the evenings and weekends.

We were told about the success of the link with the Aberdeen Council adult learning programme which connected individuals with learning opportunities at local colleges. Those we met with were enthusiastic about the opportunities this gave them.

We heard from individuals in the rehabilitation ward about the variety of activities offered and how nursing staff supported these. Some individuals complained of feeling bored and not having enough to do between the periods when they had time out of the ward.

In the acute ward, people told us there was limited activity and felt this was due to the confined space they were currently accommodated in. We found there were activities that had been planned for in individuals' care plans, but these activities were more limited when people could not leave the ward. It was recognised that this may have been due to the person's mental state and ability to engage in activity at the time of our visit. Some people we met with in the acute ward complained of being bored and having little to do.

The physical environment

At the time of our visit, the acute ward was housed in a wing of the rehabilitation ward. There was a four-bedded dormitory, two single ensuite bedrooms and a communal living space. There was a shower room, accessed in the dormitory for those accommodated there, as well as toilet facilities accessed from the communal area.

The nursing office had been accommodated in another single room and was cramped with an open toilet and shower in the room. The rehabilitation ward comprised of two, six-bedded dormitories with a shower room in each and three single rooms. There was a communal area with another adjoining room that was being used as a gym area.

Both wards had access to a secure, enclosed garden area and an occupational kitchen. Both wards were cramped and required decoration.

Individuals and staff told us about the impact of the environment on delivering safe care, particularly with a significant number of ligature points, a lack of space, and windows that were sealed, not allowing fresh air into the ward.

The Barron Report: Independent Forensic Mental Health Review : final report was commissioned by the Scottish Government and published in 2021. This report was

particularly critical of the current dormitory style units in Scotland, such as the Blair Unit, including both the acute and rehabilitation wards. 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. Although we were glad to hear the progress in undertaking refurbishment work, we were disappointed to hear that the refurbishment of the Blair Unit will not include installing partition walls in the dormitory area of the ward.

We agree with the views of the Barron Report, in that individuals who require to be admitted to a forensic ward 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 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 should review their audit processes that are currently in place to improve the consistency and quality of care plans, to ensure that evaluations of care plans clearly indicate the effectiveness of the interventions being carried out, and any required changes to meet care goals. Care plans should clearly evidence individual participation.

Recommendation 2:
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 individual's needs.

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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