Mental Welfare Commission for Scotland

Report on unannounced visit to:
Royal Cornhill Hospital, Brodie Ward, Cornhill Road, Aberdeen, AB25 2ZH

Date of visit: 30 April 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

Brodie Ward is a 10-bedded, mixed-sex ward based in Royal Cornhill Hospital that specialises in caring for individuals who have an acquired brain injury or neurological disorder, with severe psychological and behavioural symptoms. The ward also cares for people with Huntington's disease.

On the day of our visit, there were nine people on the ward with another on pass.

We last visited this service in December 2023 on an announced visit and made recommendations on risk assessment and risk management plans and the hospital's boarding protocol. The response we received from the service was in a detailed action plan. Since our last visit we have received a copy of NHS Grampian's standing operating procedure (SOP) on the boarding of individuals in other wards.

On the day of this visit, we wanted to follow up on the previous recommendations and hear about individuals experience of being admitted to this ward. Following on from our last visit, we were also keen to know about people who had been admitted to Brodie Ward and who were 'boarding' but not meeting the criteria for admission to this specialist service.

Who we met with

We met with five people and reviewed the care records of four of those people. We also met with one relative.

As this visit was unannounced, we requested that the senior charge nurse (SCN) inform other relatives of our visit in order to provide them with an opportunity to speak with the Commission following our visit, should they wish.

We spoke with the senior charge nurse (SCN), other ward-based nursing staff and the consultant psychiatrist. We also met with the service manager and the clinical nurse manager at the end of day feedback session and spoke to advocacy services following the visit.

Commission visitors

Tracey Ferguson, social work officer

Alison Thomson, nursing officer

What people told us and what we found

Given the complexity of people's needs in Brodie Ward, we were aware that some individuals had been in the ward for a longer period than others; they presented with significant complex physical and mental health needs, as well as limited verbal communication.

It was positive to hear from the SCN who told us about the progress of individual discharges since our last visit and of the progress that was being made with other individuals' whose discharge was being planned. The SCN also told us that due to the complexities of individuals' needs, finding suitable placements locally was a challenge, which was similar to what we heard on previous visits.

We introduced ourselves to everyone in the ward and where we were able to have more detailed conversations with some individuals, they described the staffing team as "good", "helpful", and "supportive". One person described the staff as "the best", while another person told us that they would ask the staff if they needed help or support. A few individuals were able to tell us about the reason for their admission to the ward and about the plans towards their discharge.

One person told us they liked being in the ward and that they did not want to leave hospital. Individuals were able to tell us about the activities that they enjoyed participating in, both on and off the ward and one person told us about the plentiful activities on offer, but they chose not to participate in.

We spoke to one individual who was not happy at being in the ward; we wanted to make sure that the individual knew about their rights and were able to exercise these.

The relative that we spoke with told us that they felt involved in their relative's care and that the staff encouraged this. The relative described the staff team as "caring" "supportive" and "experienced" in delivering the care that was required.

The relative regularly attended the multidisciplinary team (MDT) meeting, which provided them with an opportunity to raise any issues and discuss their relative's care and treatment.

The staff that we spoke to on the day described their team as "good", "supportive" and that there was "very good leadership in place". We got the sense from speaking to the staff that they knew the individuals well and had the knowledge base and skills required to support people with behaviours that challenge. We saw staff interacting in a calm and supportive way to support people with stress and distress behaviours.

Care records

Care records were held on the electronic system, TRAKCare. The SCN told us that most records were now on this system, however the ward continued to keep a paper record of legal orders and other documents that needed to be kept.

Care, treatment, support, and participation

The care and treatment on Brodie Ward was provided by a variety of multidisciplinary professionals such as nursing staff, occupational therapy (OT), psychology, GP, pharmacy and psychiatry**.**

We were told that access to other allied healthcare professionals such as a dietician, physiotherapy and speech and language therapy (SaLT) was by referral and that their support was invaluable when a need was identified.

The care plans in place were very detailed, personalised and focussed on individual strengths. The level of detail described in the interventions to meet the individual goal provided clarity of the complexity of an individual's needs, providing a rationale as to why a higher staffing ratio required.

Where an individual was able to contribute to their plan, we saw evidence of this in the care record, and where they were not, this was also recorded.

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.

The daily nursing recordings described the person's day and in particular, when they were managing an individual's stress and distress symptoms, detailing the interventions required. When non-pharmacological interventions were utilised, there was a clear recording of this as well as when 'as required' medication was administered. We found that there was a good description of the reasons why medication was administered, the benefits/effect of the medication, and ongoing review.

Although one-to-one meetings between individuals and staff were identified in the care plan, we found that these were often not recorded in the care records by staff, but from reading the entry in the nursing notes, we could see that one-to-one meetings were taking place. We were also aware that some individuals would not be able to have a one-to-one meetings due to their level of stress and distress, however staff were still able to provide details about the person's day, their views and recorded this in the care records.

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

We felt that some of the records lacked detail from when people were participating in community-based activities with staff. There were entries that simply recorded that the person “enjoyed a walk out at the park”. We had a discussion with the SCN about this, as often being out of the ward environment provides the person with an opportunity to talk about issues such as admission and treatment. We felt this would be an opportunity to record this contact as a one-to-one meeting and capture individuals’ views.

We found ‘do not attempt cardio-pulmonary resuscitation’ (DNACPRs) forms in place which were completed appropriately, along with ‘getting to know me’ documents that were comprehensive and complete.

On reviewing the care records, we saw detailed evidence of physical health care monitoring.

We wanted to follow up on our last recommendation about risk assessment and risk management plans. We were informed from the action plan that the service sent, following on from our last visit, that regular review of the risk assessments and risk management plans would be through discussion at the MDT meetings. Monthly auditing of MDT records, inclusive of risk assessments, would also be undertaken.

We were told that all risk assessment and risk management plans were now completed on TRAKCare. All care records we reviewed had a risk assessment in place that were mostly detailed, however the level of detail in the risk management plans varied. We also found that there was no clear standard in place for when the risk assessment and risk management plans were reviewed; we found some were reviewed less frequently than others.

The care plans that we reviewed identified the complexity of individual needs, often describing risk associated with behavioural symptomology, stress and distressed behaviours, including falls and multiple physical health issues.

On reviewing the care records, we found details regarding the level of risk and interventions recorded in the care plans as opposed to a specific risk management plan. We viewed the MDT meeting record and found that there was a prompt on whether risks were discussed, which was recorded as ‘yes’ or ‘no’. We found that the risk assessments and risk management plans on TRAKCare were not always being reviewed following the MDT meeting.

There has been further contact with the service since the visit took place, regarding the developments that are taking place nationally in relation to managing risk and personal safety planning. It is anticipated that health boards and their services will move towards a more tailored approach that is shared with the individual and look forward to seeing how the service develops across the services in NHS Grampian.

Recommendation 1:
Managers must ensure that all documentation where risks are detailed provide an account describing how each risk will be managed, along with evidence of ongoing and regular review, and that there is an audit process in place that will monitor this.

Multidisciplinary team (MDT)
The MDT meetings took place weekly and individuals could meet with their psychiatrist before, or after, these meetings.

The ward continued to have regular input from the GP to assist with physical health matters and the GP was also part of the weekly MDT meetings. Pharmacy also continued to provide regular input to the MDT meeting. We had been told on our last visit that the clinical psychologist post had been filled, however we were also told that there had been periods of absence which had an impact on completion of formulation planning and neuropsychological assessments.

The SCN told us that the ward now had a dedicated OT. We also heard about discharge planning meetings where social workers and mental health officers (MHOs) attended, which we found documented in the care records.

The MDT meeting record was held electronically and included a note of who attended the meeting, along with the actions and outcomes of the meeting; the record also included family and individual views.

The level of detail in the MDT record varied across the records we reviewed. Given the complexity of individuals in this ward and the number of multidisciplinary professionals involved in their care, we would have expected comprehensive records completed for each MDT meeting.

Recommendation 2:
Managers must ensure that there is detailed recording of the weekly MDT meeting and that there is a robust audit tool in place to monitor compliance with this.

We wanted to follow up on our recommendation about the boarding protocol. We received a copy of the NHS Grampian standard operating procedure which outlined what should happen when a person is boarded out with their speciality area. We were pleased to hear that since our last visit there had only been a small number of people who were admitted to Brodie Ward under the boarding protocol, and that this was not a regular occurrence.

Use of mental health and incapacity legislation
On the day of the visit, six people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

We were told that all documentation relating to the Mental Health Act was stored in the paper records, however, we could not locate some of the Mental Health Act certificates.

Since our last visit to this ward, NHS Grampian had moved to the electronic prescribing system, HEPMA (Hospital Electronic Prescribing and Medicines Administration).

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. Certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed, however, one individuals T3 certificate was not in their record.

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 an individual had nominated a named person, we found this was clearly recorded in the record.

For people that were subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) there were five records where we could not locate a copy of the legal order that was in place, such as a power of attorney (POA) or welfare guardianship order.

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.

We found that all section 47 certificates had been completed appropriately, including evidence of consultation with the proxy, apart from one. We also noticed that 'discharge planning'; was recorded on two people's treatment plans, which was not appropriate as discharge planning is not considered as medical treatment. We discussed this at the feedback session with managers. All section 47 certificates were kept in the paper record.

For individuals who had a covert medication pathway in place, all documentation was in order and there was evidence of regular review. This documentation was stored in the paper record.

The Commission has produced good practice guidance on the use of covert medication.[2]

[2] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492

There was a white board in the nurses' office which clearly recorded individual essential data, including legal orders. On reviewing the paper records and the electronic records, we found the data did not match.

Recommendation 3:
Managers must ensure that all Mental Health Act and AWI Act treatment certificates, along with covert pathway documentation are kept together, accessible and easy to locate for all staff and that the ward has a copy of all current POA or welfare guardianship orders.

Rights and restrictions

The ward continued to operate a locked door that was in keeping with the level of risk identified in the group. We were pleased to see that the ward had displayed the locked door policy beside the door to the ward, which was in pictorial format.

The ward continued to have good links with the local advocacy service and there was information available on the ward about this service that individuals or relatives could access. We spoke to advocacy services who told us that the ward was welcoming and staff were supportive in providing information to people about their rights. We saw the advocacy input recorded in care records.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on individual who are detained in hospital. Where a person is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. On the day of the visit, it was recorded on the white board that there were two individuals who had been made a specified person, however, there was no documentation in their records.

We found a care plan relating to specified person restrictions, but from speaking with staff it was unclear whether the person was specified, or had ever been subject to this legislation, as there was no additional documentation. We followed this case up with the consultant psychiatrist who informed us that this person had not been made a specified person. From reading the care records, there was no evidence of restrictions being placed on the person. We found that there was no recording in the weekly MDT regarding of the review of restrictions and we were unclear what had contributed to this confusion.

Recommendation 4:
Managers must ensure that where an individual has been made a specified person that the appropriate documentation is in place, easy to locate and that there is regular review and recording of the discussion incorporated into the MDT meeting.

When we are reviewing individuals' records, 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. Where individuals were able to make an advance statement, and had chosen to do so, these were available in the care records.

We found that the ward had good information about rights displayed on the wall in the ward corridor.

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

People we spoke with were able to tell us about the activities they enjoyed and what they had in place.

We were told that activities were carried out by nursing staff, OT and the activities co-ordinator. The activities co-ordinator worked three days per week in the ward, and we were able to see recordings of activities in the records we reviewed, along with separate activity care plans.

There was an activity board displayed on the wall in the main corridor. Activities were individualised, as some people were able to engage in activities for longer than others, and some people did not wish to engage at all. We heard that some people preferred to spend their time watching television and listening to music, instead of engaging in ward activities.

The ward had access to a vehicle to take people out in the community, which individuals told us they enjoyed. Due to complexities of individuals' care, the staff told us that the ward benefitted from having access to the vehicle, as otherwise it would be difficult to get people out. However, there were limitations, as the vehicle was not wheelchair accessible.

The ward had a pool table, a variety of board games, arts and crafts. We saw people out in the garden during the visit, playing a board game with staff.

The physical environment

The ward compromised of single en-suite rooms and dormitories. We were told that there were still occasions where individuals had to share bed space, however, this was not the case on our visit. We saw an example where one individual had a

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

dormitory to themselves, with access to their own bathroom, and the area had been personalised to make it more homely. Most individuals had personalised their bedrooms, with pictures on the walls and televisions in their rooms.

One of the dormitories continued to being used for storage space, and it included people's wardrobes, a staff break out area and storage of arts, crafts, and ward equipment. The ward did not have a separate space for activities; these were carried out in the dining area, where people had their meals.

From the dining area there was access to an enclosed garden and we were pleased to hear that the slabs had been levelled since our last visit. Given the number of people in the ward, we felt that the space was being used well.

On the day of the visit, we saw that the water flow from the ward above was coming down to the Brodie Ward garden. This had been reported and we were advised that this was being dealt with.

The specialist bath in the ward was not working and the SCN told us that this required specialist parts that had been ordered.

We saw that some rooms had curtains hanging across their windows and that hooks were missing, which made the environment look untidy. Managers told us that each curtain was not permitted to have any more than three hooks. This had been agreed with Health and Safety as part of risk management due to this ward having no ligature reduction works completed. Given the lack of ligature reduction works, it is essential to ensure this is assessed and recorded as part of individuals' risk management plans.

We were aware that a report was previously completed by the consultant psychiatrist and submitted to senior managers regarding the ward's criteria and the need for improvements to the ward environment. We were disappointed to hear that there were no plans to upgrade the ward.

Summary of recommendations

Recommendation 1:
Managers must ensure that all documentation where risks are detailed provide an account describing how each risk will be managed, along with evidence of ongoing and regular review, and that there is an audit process in place that will monitor this.

Recommendation 2:
Managers must ensure that there is detailed recording of the weekly MDT meeting and that there is a robust audit tool in place to monitor compliance with this.

Recommendation 3:
Managers must ensure that all Mental Health Act and AWI Act treatment certificates, along with covert pathway documentation are kept together, accessible and easy to locate for all staff and that the ward has a copy of all current POA or welfare guardianship orders.

Recommendation 4:
Managers must ensure that where an individual has been made a specified person that the appropriate documentation is in place, easy to locate and that there is regular review and recording of the discussion incorporated into the MDT meeting.

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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