Mental Welfare Commission for Scotland

Report on announced visit to: Great Western Lodge, 375 Great Western Road, Aberdeen, AB10 6NU

Date of visit: 7 April 2016

Where we visited

Great Western Lodge is a NHS community rehabilitation forensic service with facilities for 8 individuals. The service is based in residential housing with an open door policy, each resident having a house key. Although based in the community, the lodge operates as a hospital service where patients can still be subject to detention.

We last visited this service on 1 October 2014 and made the following recommendation:

Hospital managers should develop a flagging system to ensure that reviews are undertaken timeously where individuals are made subject to Specified Persons measures.

On the day of this visit we wanted to follow up on the previous recommendation and also to look at care planning and physical health monitoring.

Who we met with

We met with 4 people who use the service and reviewed a further two files.

We spoke with the senior charge nurse.

In addition, we met with 2 consultant psychiatrists and the service manager at the end of the visit.

Commission visitors

Douglas Seath, nursing officer and co-ordinator

Paula John, social work officer

What people told us and what we found

Care, treatment, support and participation

Individual patients who were seen on the visit did not raise any significant issues about their current care and treatment, in any of the wards. We heard a number of positive comments about support provided by nursing staff, and also about current treatment authorised by medical staff in the unit. There is also regular input from occupational therapy and good access to clinical psychology.

There were detailed care plans in place for all patients and reviews were well documented. However, reviews were more comprehensive for forensic patients, those for civil order patients being more limited in scope and content. There was also a lack of evidence that patients were meeting with named nurses on a regular basis to have their nursing care evaluated.

A risk profile has been compiled for all patients with risk management plans, also in place. Minutes of multidisciplinary team (MDT) meetings were available within the case notes, detailing attendance and actions required to be taken forward. The views of the individual and their relative/carer are also incorporated into case review documentation. Where people were being managed through enhanced Care Programme Approach (CPA), this was also well documented and easily identified.

Patients told us how nursing staff supported and involved them in discussions about their care and treatment and how they feel they can put their views across in these CPA meetings. Some people spoke about meeting with an advocate and those who had chosen not to make use of advocacy, nevertheless seemed to be aware that the service was there for them if they wanted to access it.

Little use was made of advance statements and those we did find mainly concerned restricted patients.

Recommendation 1

Managers should ensure that reviews of care plans for civil patients replicate the good practice exemplified in care plan reviews for those subject to forensic orders.

Recommendation 2

Regular audit should be carried out by the managers to identify that meetings which patients have with their named nurse, are clearly documented in care files.

Recommendation 3

Managers should emphasise the advantages of all patients writing advance statements to reflect their future preferences.

Use of mental health and incapacity legislation

Mental Health (Care & Treatment) (Scotland) Act 2003 (the Mental Health Act) documentation was well maintained in personal files. Medical treatment under part 16 of the Mental Health Act was authorised appropriately on the relevant consent to treatment certificate (T2) and certificate authorising treatment (T3) forms. We also noted that associated high dose monitoring checks were being completed where this was appropriate. Prescriptions were all completed accurately and 'as required' medications clearly defined.

Sections 281 to 286 of the Mental Health Act provide a framework within which restrictions can be placed on people who are detained in hospital. Where a patient is a Specified Person in relation to these sections of the Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised, and that the need for specific restrictions is regularly reviewed.

Responsible medical officers (RMOs) have to complete certain forms in relation to Specified Persons. We saw that the necessary notification forms were in place in the wards, where this was appropriate. We also saw that specific restrictions being applied were well documented in care plans, and that restrictions were being reviewed by RMOs with reasoned opinions on file, as recommended in our previous visit report.

Rights and restrictions

One patient expressed concerns about his RMO being overly cautious about the time he is permitted to stay overnight on suspension of detention (SUS) in his place of residence. However, this level of caution was in keeping with the assessed risk based on past behaviour patterns. He was advised that SUS provision is a matter based on the clinical judgement of the clinicians and not something the Commission has authority to review.

Smoking is banned in the lodge and there has been some opposition from local residents to patients smoking in the street. However, there are no other options as the garden is also no smoking. Patients are offered help from specialist staff to stop smoking and some have taken the opportunity to do so.

Activity and occupation

A good range of leisure, recreational activities and employment appear to be available to patients in the lodge with each individual having their own activity programme. We did hear a number of positive comments about activities, and about work placements with patients benefitting from: working in a local cafe; gaining experience at a walled garden; trips to town; and going for accompanied walks with community staff.

In addition, all patients took part in cleaning, shopping, cooking, doing laundry and other activities in preparation for discharge from hospital care. The occupational therapist mainly carries out domestic assessments and assists with activities to support rehabilitation programmes.

The physical environment

Great Western Lodge is a Victorian villa with all of the limitations of a building of that age. The lodge has benefitted from a painting programme and new furniture and flooring in the sitting room. We were told on the day that maintenance and redecoration is ongoing. The communal spaces i.e. sitting room, kitchen and dining room are well used by residents. With regard to outside space, there is a programme of work to improve the back garden area and this should resume in the spring and summer months.

Any other comments

Physical health monitoring

There was little evidence of efforts to review physical health. We were informed that patients have annual health checks but, as this is carried out by GPs, it is not recorded in the care file. Many of the patients have an issue with weight and fitness due to time spent in hospital and the side effect of psychotropic medication.

The results of these checks should help staff monitor the efforts being made to deal with physical health issues and to plan programmes of care accordingly. Doctors, who we met with at the end of the visit, have a meeting with GPs scheduled at which they plan to discuss how information about physical health can be shared.

Recommendation 4

Managers should liaise with GP colleagues to find a way to share information regarding physical health checks on patients.

Summary of recommendations

1. Managers should ensure that reviews of care plans for civil patients replicate the good practice exemplified in care plan reviews for those subject to forensic orders.
2. Regular audit should be carried out by the managers to identify that meetings which patients have with their named nurse, are clearly documented in care files.
3. Managers should emphasise the advantages of all patients writing advance statements to reflect their future preferences.
4. Managers should liaise with GP colleagues to find a way to share information regarding physical health checks on patients.

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

Kate Fearnley

Executive Director (Engagement and Participation)

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.

Contact details:

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

telephone: 0131 313 8777
e-mail: enquiries@mwcscot.org.uk
website: www.mwcscot.org.uk