Mental Welfare Commission for Scotland

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

Date of visit: 5 November 2024

Where we visited

Great Western Lodge (the Lodge) is part of NHS Grampian's forensic rehabilitation service and provides single accommodation for eight males, who are preparing for discharge to the community.

On the day of our visit, there were eight individuals living at the Lodge. The Lodge is situated in a residential setting in Aberdeen city and all individuals had been admitted there from the Blair Unit in Royal Cornhill Hospital. The Lodge is an old Victorian-style house that provides accommodation over five levels and has no disabled access.

We last visited the Lodge in November 2023, on an unannounced visit and made a recommendation about individual's weekly catering budget. We received an action plan from the service and were pleased to hear from managers that individual's weekly catering budget had been increased and the budget would now be reviewed annually.

On the day of this visit, we wanted to speak with individuals, relatives, and staff.

Who we met with

We met with four individuals and reviewed their care and treatment.

We spoke with the nurse manager, the senior charge nurse (SCN) and other nursing staff. We made contact with the advocacy service, based at Royal Cornhill Hospital.

Commission visitors

Tracey Ferguson, social work officer

Lesley Paterson, senior manager (practitioners)

What people told us and what we found

Since our last visit, the SCN told us that one person had been discharged to a community facility and the Lodge has had one admission from the Blair unit. Most of those that we met last year have continued to stay in the Lodge, participating in their rehabilitation goals, and actively preparing for the next stage of their recovery journey in the community.

On this year's visit, we gained the sense that the staff knew the individuals well. All the individuals had come through the forensic pathway, where the staff team in the Lodge have had the opportunity to work across all the forensic wards in the Blair unit.

Each individual was at a different stage of their rehabilitation journey, and we received an update from the SCN about how everyone had progressed since our last visit. We heard how some individuals were more independent than others, who required more rigorous monitoring and support to aid their rehabilitation. We were told that some individuals were at the stage of discharge planning and that suitable accommodation and community support was being sought.

Feedback from those that we spoke with was positive about their stay in the Lodge. Individuals told us that nursing staff were always available and that the regular one-to-one sessions with staff were helpful. Individuals described feeling engaged in their care and treatment and told us about the opportunities they had to discuss this with their consultant psychiatrist and nursing staff. We heard about meetings with the RMO (responsible medical officer), the wider team of multidisciplinary professionals and Care Programme Approach (CPA) meetings. 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 by involvement of a range of different people and by keeping the individual and their recovery at the centre.

Everyone we spoke with was able to tell us about their current medications, their rights and about access to advocacy services. Individuals told us about their weekly activities that they were undertaking to achieve their rehabilitation goals and where they required support. It was positive to note where progress had either been maintained or progressed since our last visit.

Individuals told us they enjoyed having their own bed space, while others told us that they enjoyed coming together for things such as social evenings and group outings.

The nurse manager told us about the change in SCN since our last visit. We were told that the SCN had moved to a seconded post and that the current SCN had been in post since September, having come from another ward in the forensic service. We were told that the Lodge was fully staffed at present with no vacancies, which was positive to hear.

Managers told us that the more recently, the staff team had been dealing with more complex situations, and higher levels of acuity. We were told that previously where an individual's mental health had deteriorated, they would have tended to be transferred back to a ward in the Blair Unit. However, due to bed capacity in the unit, this has not always been able to happen.

Although we heard about the challenges of this, managers and staff told us that by providing additional support and monitoring that the person required, this had enabled individuals to remain at the Lodge, in a place that they had become familiar with, and continue with their recovery once their mental state had stabilised.

Care, treatment, support, and participation

Care plans

We had been made aware on our last visit that there was a working group across the Royal Cornhill site that was reviewing care planning documentation and processes to improve this, and that the documentation was just being rolled out on our last visit.

On this visit, it was positive to see that all care plans had been changed to the new documentation. We found the care plans that were in place were detailed, person-centred and identified goals, along with detailed interventions to meet these goals. We reviewed one individual's care plan where we found that the current plan did not cover all their needs and we felt that a separate care plan was required for physical health care. We discussed this with the SCN who agreed to action this.

All the care plans we saw were being reviewed regularly and while most of them had detailed summative reviews, some reviews provided limited information and only recorded "remains relevant".

We found that participation in the process had improved, with some individuals either having signed their care plans, and/or had a copy of the document, or told us about the process and of the goals they were working towards. Where a person did not wish to sign, this was also recorded.

The new documentation had a 'patient goals' section, but we found that this section was not always being completed. However, it was clear from other recordings that they had been involved in developing their plans, where they wished to.

We were made aware from other visits that a new audit tool had been devised as part of the improvements and there had been an audit carried out across the other wards in the hospital in order to see how the tool was working. We discussed this further with the nurse manager on a recent visit to the Blair unit and as the Lodge is part of the forensic service, we will request an update from the nurse manager about recent audit outcomes.

Care records

Managers told us that some documentation had recently been transferred to the electronic system TRAKCare, which was being rolled out across NHS Grampian. We accessed individual electronic files on the day of the visit as well as some paper files that were still in place. The SCN told us that the plan was for the unit to eventually have all recording and documents transferred over to the electronic system. We were told that all the ward-based staff and the multidisciplinary team (MDT) record all daily contact with individuals on this system; the weekly MDT meetings were also recorded on this system. We are aware of plans to roll this out to all mental health and learning disability wards across NHS Grampian, which we hope will be helpful with the integration of records.

With nursing staff daily recordings now being completed on TRAKCare, we found the entries to be detailed, relevant, and meaningful in that the recordings provided a good level of progress updates about the care and treatment of the individual that incorporated their views. We saw evidence of one-to-one meetings happening between the nursing staff and the individual, as well as regular meetings that individuals had with their RMO. We felt all multidisciplinary staff now using the electronic recording system was an area of improvement, as records and updates about individual's care was now being recorded in one place, as opposed to having separate recording systems.

In terms of risk assessments and risk management plans, we found a rapid risk assessment in each of the care notes, and details of risk included in care plans. We were told that each individual's risk assessment, an HCR-20, would be updated by the forensic psychologist on an annual basis, and although we found some of these in the paper files, we found other files where these had not been inserted.

We advised the service that while it was in an interim period between paper files and electronic files that important documents, such as risk assessments and risk management plans, should be kept in the paper file until the document had been uploaded onto the electronic system.

Multidisciplinary team (MDT)

We were told that the MDT meetings continued to take place weekly and consisted of the consultant forensic psychiatrists, nursing staff, occupational therapy (OT), the forensic clinical psychologist, along with input from pharmacy. We heard that social workers and MHOs also attended the MDT meeting, but not every week.

It was positive to hear that the MDT provision has continued to be the same for all individuals across the forensic wards, and all had access to the full range of disciplines throughout their rehabilitation journey.

The weekly MDT meeting was now being recorded on the electronic system TRAKCare and of the records that re reviewed, they provided a detailed overview and update of the individual's care and treatment. The record noted the names of who was present the meeting, along with outcomes and actions and individual requests.

We found the new electronic recording format to be robust and it covered all necessary aspects of a person's care and treatment, including the ongoing monitoring of their 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 on a regular basis either in the Lodge or at the outpatient clinics.

From our review of the care records, we saw evidence of this, along with the individual's views being sought and recorded. A new format enabled helpful prompts that prompted reviews of treatment. Staff told us that they were getting used to this new format, which was much needed and we heard that there has been an improvement in a short space of time. The leadership team told us that there may be some areas in the electronic system which require to be improved, however we were pleased to hear that the staff had adapted well to this well.

All individuals were subject to CPA, and we found minutes of these meetings in the individual's file. We were told that these meetings were held no less frequently than six monthly, but could be held more often, depending on where the individual was in their rehabilitation journey. Where some individual's progress had them nearer to discharge, we saw further planned dates for these meetings as part of the discharge planning process. We were also told that the forensic pathway nurse would attend these meetings, that they were the link between the hospital and community and that this role had been a beneficial addition to the service.

We were pleased to see evidence of individual participation at these meetings, along with support from advocacy. The care plans and risk assessments which formed part of the CPA documentation were detailed and we were able to see on this visit how the detail was incorporated into the individual care plans.

We were told that each person was registered with a GP when they move to the Lodge and all annual physical health checks were undertaken by the GP surgery. Where an individual attended the clozapine clinic, all specific checks were undertaken there. Nursing staff provided support to individuals with appointments, where required and updates were brought back to the weekly MDT meeting. We found there was a good level of detail with regards to physical health checks and there was an emphasis on healthy living and eating at the Lodge, similar to what we found on last year's visit.

Use of mental health and incapacity legislation

On the day of the visit all individuals in the Lodge were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act), or the Criminal Procedures (Scotland) Act, 1995 (Criminal Procedure Act); we found that the detention paperwork was in order and easy to find in the paper record.

The Lodge 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 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 a few issues with consent to treatment certificates (T2) and certificate authorising treatment (T3) under the Mental Health Act. We discussed these further on the day of the visit and provided details to the consultant forensic psychiatrist and SCN.

With the service now recording the MDT meeting on TRAKCare, this system provided a prompt with regards to T2/T3 certificates, enabling the service to review these as part of the MDT meetings and ensure individual rights were 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 these in the care record.

Rights and restrictions

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 to promote advance statements and when we are reviewing individual records, we look for copies of them.

Where individuals had chosen to complete an advance statement, we found copies in their records and this information was also recorded on the CPA documentation. From reviewing the care records, we saw that staff had continued to discuss and support individuals with these and where a person did not want to complete one, this was clearly recorded. It was positive to see that more than half of the individuals at the Lodge had made an advance statement.

The Lodge is permanently open with no restrictions on access to rooms and individuals had their own keys. For the purpose of monitoring suspension plans, the

staff kept a record of when an individual had time out of the Lodge, and this was confirmed in the risk management plans.

Section 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital. Where an individual 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. The Commission would expect restrictions to be legally authorised and that the need for specific restrictions to be regularly reviewed, along with reasoned opinions which should be documented in the records.

We found that where an individual had been made a specified person that all paperwork, including the reasoned opinion, was in order, apart from one individual. This person had been made a specified person for mail and correspondence however we could not find the appropriate RES6 form completed in the file. We brought this to the attention of managers at the end of day feedback meeting.

We had a discussion with managers and the consultant forensic psychiatrist about individual's continued need for being made a specified person. Given that some individuals were nearing discharge and specified person legislation cannot be applied in a community setting, we felt it was appropriate for the ongoing justification of the need for this legislation to be closely reviewed, and consideration given to care plans being devised in a way that 'tests out' the individual's compliance with their care and treatment.

The local advocacy service, who were based in Royal Cornhill Hospital, told us that the advocates continued to be invited to meetings and that the managers were good at asking people for feedback. An advocate told us that mental health officers (MHOs) often referred individuals for advocacy support. On reviewing care records and from speaking to individuals it was apparent that the Lodge had good links with the local advocacy service and the individuals valued the support they received from the service.

The Commission has developed *Rights in Mind.*[1] 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

Most of the individuals in the Lodge had spent long periods of time in hospital, which had had a significant impact on the skills and abilities needed to community living. We would expect that an inpatient forensic rehabilitation service would have

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

individualised activities to promote recovery, which would help individuals gain or regain the skills and confidence needed to progress their recovery.

On last year's visit we were told that the Lodge had access to two activity nurses who provided input across the three wards in the Blair Unit. However, on this visit, we were told that most activities were undertaken by the nursing staff and health care support workers.

We heard that the Lodge had frequent group social outings in place, and other social events, such as movie nights, bowling, takeaway nights and more focussed groups where specific topics would be discussed, such as oral health or men's health. We were told that there was access to the hospital pool cars if needed for activities. The Lodge continued to have residents' meetings to discuss issues, including planning social events. We saw evidence in individual records of the one-to-one and group activities that were taking place to support individuals in the community and in the Lodge.

We found that the Lodge had a strong emphasis on rehabilitation and supporting individuals to move onto the next stage of independent living, and we found activity planners to support this. Individual planners were not solely activity-based but provided the individual with structure and routine for rehabilitation purposes, such as domestic chores, shopping, cooking, and personal care. Each planner reflected where the individual was in their rehabilitation journey, and each person had a copy of their planner in their rooms.

We heard how some individuals had been supported by the OT to find a volunteering job and other community activities that they wanted to do, which included travelling to them. Individuals had access to OT and this support had continued as part of their transition from the Blair Unit. We were told that the OT or nurse would initially support the individual to identify what they would like to do, then support them with the planning and progress required to move to the next stage.

All individuals in the Lodge were encouraged to cook for themselves according to their skills ability, with assistance provided from staff if required. Some individuals told us that they enjoyed cooking and how they cooked every meal themselves. Last year we were concerned to hear that the weekly catering budget, to support individuals with their rehabilitation, was at times not managing to cover the essentials they required. Everyone was allocated a weekly catering budget of £31, however this had now increased to £35 per week and staff confirmed there will be an annual review of this budget.

The physical environment

The Lodge is a Victorian style house that had two large front rooms, one that is a lounge for individuals where there were ample couches and a television, and the

other was for staff. We were told that the television in this room that had been broken had now been replaced.

The staff room was multi-purpose, where all individual records are stored, along with staff computers, and where medications were stored; individuals attended this room for their medication, when they were not self-medicating. There was no separate staff break room.

The Lodge had a kitchen installed in 2022, and we heard from individuals that this facility had supported their rehabilitation. There was a dining area off the kitchen where individuals were encouraged to eat, and a large garden to the rear of the building with a gate that led to the street.

Individuals all had a single room with a wash hand basin. There was one shower room and another shared bathroom. However, on the day of the visit, one bathroom was out of action due to Covid-19. There were water marks on the ceiling in the shower room that were there on our previous two visits. We had highlighted on previous visits that some of the seals in the shower room would benefit from re-sealing, as the silicone was starting to go black. While we saw some re-sealing had happened, there were other areas that were the same.

The SCN told us that some rooms had new flooring, and the plan would be when a person moves on from the Lodge, the vacant room would be decorated before another person was transferred. The back stairwell and vestibule area at the backdoor was clearly in need of re-decoration. We were told that the dishwasher had been out of action for months and although a new one had been purchased, this was not an integrated appliance, which was needed for the kitchen.

Staff told us that the office printer had also been out of toner for around four months, and they had been initially told if they required to print any documents off, this needed to be done at the main hospital. We were pleased to hear that the staff were subsequently provided with toners; given that the Lodge is in a community setting, travelling to the main hospital for printing purposes would not be an efficient use of staff time.

We were told that there continued to be a monthly workplace inspection and an annual inspection of the property where issues and concerns were identified, and senior managers were alerted. However, we heard at last year's visit that any identified works could take an extended period of time, which was again similar to what we heard on this visit.

Whilst we have seen some progress on previous visits, due to the style and age of the house, the environment will require ongoing upgrading, and a continuous programme of works to ensure the health, safety and wellbeing of the individuals and staff who reside and work at the Lodge.

The Barron Report: Independent Forensic Mental Health Review was published in February 2021 made recommendations regarding the physical environment of forensic services and that Health boards were required to address these issues. As Great Western Lodge is part of the forensic pathway, we requested an update from managers about ongoing current and future works to the Lodge. We were told that the current priority was the Blair unit and that there was no planned works for the Lodge.

Recommendation 1:
Senior managers must ensure there is a programme of work, with identified timescales, to address the environmental issues and outstanding repair and refurbishment work.

Summary of recommendations

Recommendation 1:
Senior managers must ensure there is a programme of work, with identified timescales, to address the environmental issues and outstanding repair and refurbishment work.

Service response to recommendations

The Commission requires a response to this recommendation 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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