Mental Welfare Commission for Scotland

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

Date of visit: 4 June 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

Great Western Lodge (the Lodge) is part of NHS Grampian's forensic rehabilitation service. It provides single room accommodation for eight men, 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; 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; there is no disabled access.

We last visited this service in November 2024 on an announced visit and made one recommendation about the environment.

On the day of this visit, we wanted to follow up on the previous recommendation that the service improve the environment for individuals. We had received an action plan detailing the steps that would be taken towards achieving this and were keen to see what progress had been made.

We were also keen to hear the views of individuals, families and staff about the care and treatment in the Lodge.

Who we met with

We met with three people and reviewed their care and treatment; we reviewed the care records of another individual. We also met spoke with one relative.

We spoke with the service manager, the senior charge nurse (SCN), the nurse manager and one of the consultant psychiatrists.

We received feedback from the advocacy services who supported individuals in the Lodge. They told us they felt advocacy services were well supported by the staff in the Lodge and they felt the service valued and understood the advocacy role well.

Commission visitors

Susan Hynes, nursing officer

Mary Hattie, nursing officer

What people told us and what we found

Since our last visit, the SCN told us there had been some new admissions with some people who had lengthy admissions being successfully discharged to community placements.

We were told there had been some breaches of security measures in the kitchen, dining and laundry areas which necessitated the locking of these areas. Individuals were able to access them as needed, but with staff present. This had caused some frustration from individuals in the Lodge as well as adding pressure on staff.

We heard how the service had attempted to manage the risk posed by the breaches both by increasing staffing and taking an incremental approach to restricting access but unfortunately it had been required to lock these areas. This was being kept under review and regular consideration was being given to the requirement for these restrictions.

We were satisfied that the service's response to these issues was proportionate to the risks identified. We heard from some of the individuals that we met with that they were frustrated by the increased level of security but that they understood the rationale, which this was discussed with them regularly.

We heard from individuals that they felt they were fully involved in the planning and review of their care and were told how staff ''really listen'' to their views. People we spoke to told us they were treated with respect and that they liked the more homely environment of the Lodge.

We heard from everyone that we met with that they had regular contact with nursing, medical and other staff who supported their rehabilitation goals. One person mentioned the occupational therapist (OT) had been particularly helpful for them, respecting their choices and supporting them achieve these.

One person who had moved from the Blair Unit more recently spoke of their frustration about the length of time it was taking to agree time out of the Lodge, feeling he had less to do than he had in hospital as he was no longer able to access gym facilities. We raised this on the day with the service and were assured action was being taken.

We spoke with one relative who expressed some frustration about the restrictions that were placed on their relative; they believed these were punitive and unnecessary. When we reviewed the person's records, we found the requirement for the restrictions were evidenced in the risk assessment and risk management plan. The relative praised the friendly interactions with nursing staff and told us they felt the move to the Lodge had been beneficial for their relative and they were ''getting their confidence back''.

We heard at our last visit how staff had been dealing with more complex situations, and higher levels of clinical acuity. We were told that previously where an individual's mental health had deteriorated, they would have tended to be transferred back to the Blair Unit. However, due to bed capacity in the unit, this has not always been able to happen. We were told by the service this continued to be the case and staff have become more confident at providing the additional support and monitoring required.

Care, treatment, support, and participation

Care plans were all held in an electronic format with paper copies also available in each individual's file.

We found person-centred care plans and although brief, most contained appropriate levels of information with good evidence of an individual's involvement in agreeing the goals and interventions required to achieve these.

The review of these care plans was brief and lacked the expected details about the progress an individual was making towards achieving the stated goal, most only stating 'care plan reviewed, no change'.

We saw evidence in the care records of review and the discussion that had taken place with the individual about the effectiveness of the interventions. We would have expected to see this summarised in the review section of the care plans.

Regular one-to-one sessions between nursing staff and individuals were recorded and demonstrated a person-centred approach to care.

Recommendation 1:
Managers should ensure that care plan reviews are detailed and provide a summative evaluation of the efficacy of care interventions.

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.

We found detailed risk assessments and risk management plans in everyone's paper record. There was a rapid risk assessment in each of the care records and details of risk included in care plans. We were told that everyone's risk assessment, and HCR-20, would be updated by the forensic psychologist six-monthly, and we found copies of these in the paper records.

HCR-20 (Historical Clinical Risk Management-20) is a widely used violence risk assessment instrument designed to help professionals evaluate the likelihood of violent behaviour and guide risk management strategies.

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

Care records
Care records were held electronically on the TRAKCare system and in paper format in an individual's file. We found this straightforward to navigate although there was some duplication of information with care plans in both paper and electronic format.

Staff explained it was helpful to have paper copies of care plans so these could be quickly and easily shared with individuals. We found the paper copies all corresponded with those held in electronic format.

The care plans and risk assessments that we reviewed were detailed, clear and holistic; descriptive interventions linked well to identified needs and goals. Continuation notes were informative and linked well to individuals' care plans. The language used was person-centred and trauma informed.

We saw comprehensive mental state and physical health reviews by the consultant psychiatrist and other medical staff, as well as recorded contacts with the general practitioner (GP). It was apparent from the records we reviewed that there was a full range of professionals contributing to care and treatment for individuals including nursing, medical, OT, physiotherapy, pharmacy, dietetics and social work.

There was a personal history and formulation in the risk assessment documentation that provided staff with important background information about the person.

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

The weekly MDT meeting was recorded on the electronic system, TRAKCare. Of the records that we reviewed, we found a detailed overview and update of the individual's care and treatment. The record noted who was present at the meeting, along with outcomes and actions and individual requests.

We found the 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 consultant psychiatrists also met with individuals on a regular basis either in the Lodge or at an outpatient clinic. The forensic pathway nurse attended the weekly MDT meeting and any relevant CPA meeting; they worked between ward-based and community-based care to support the transition period leading up to and following

discharge. We heard how this role allowed support to be provided to access community resources that could be continued following discharge.

The care programming approach (CPA) is a structured process for organising care for individuals with complex mental health, learning disability or forensic needs. It brings together professionals, service users and carers to create and review a single, coordinated care plan.

All individuals in the Lodge were subject to CPA, and we found minutes of these meetings in each 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. There were detailed care plans and risk assessments as part of the CPA documentation, and we saw this information was incorporated into people's care plans and activity planners.

We heard that each person was registered with a GP and annual physical health checks were completed at the GP surgery. We were also told how individuals who may require ongoing medication monitoring were supported to attend the community review clinics to help with the transition to community-based care. Updates from these clinics were brought back to the weekly MDT meeting.

We heard from individuals about the support they received from advocacy services and saw evidence of how the service was involved with those who accessed it.

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 used the electronic prescribing system, HEPMA (hospital electronic prescribing and medicines administration). All treatment certificates were kept in individuals' 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 no issues with consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act. TRAKCare provided a prompt with regards to T2/T3 certificates, enabling the service to review these as part of the MDT meetings.

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. This was revisited with the person if they had previously declined to have a

named person. Everyone we spoke with on the day of the visit was able to tell us about their current medications, their rights and about access to advocacy and legal services.

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.

There were no restrictions on access to people's rooms and individuals had their own keys. As previously noted, on the day of our visit, the kitchen, dining area and laundry room were all locked with access supervised by staff. This was part of a risk management plan and was being reviewed regularly; individuals in the Lodge had been involved in the discussions about this matter.

Staff monitored suspension/time out plans, by keeping a record of when an individual had time out of the Lodge, and this was confirmed in the risk management plans and care 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, all of the paperwork, including the reasoned opinion, was in order. Everyone we spoke with had been informed in writing about being specified and were aware of their rights in relation to a review.

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. 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.*[2] 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

Many of the individuals in the Lodge had spent long periods of time in hospital, which can significantly impact on the skills and abilities individuals would need to live in the community. We would expect that an in-patient rehabilitation service would have individualised activities to promote recovery, and to help people gain, or regain, the skills and confidence needed to progress. We would expect to see these activities recorded in activity planners/timetables.

We were told that everyone had a weekly planner in place. These planners were not solely activity-based, they also provided the individuals with structure and routine for rehabilitation purposes and recorded activity such as shopping, showering and chores. People we met with showed us a copy of their activity planner and told us that they were out and about in the community most days. One person did raise that their access to activities had reduced due to there not being an onsite gym and their community access plan needed reviewed. They expressed some frustration at the time this was taking to be done. We checked with the team and were reassured this was in the process of being reviewed.

Each person was at a different stage of their rehabilitation journey, and their planners reflected this. Individuals told us about their daily activities and how this supported them to develop skills helping them to move on. They also told us about their voluntary placements and other community-based activities that they enjoyed. We heard about social outings, and how the Lodge had regular community meetings to discuss issues, including planning social events. We saw evidence in the people's records of the one-to-one and group activities that were supporting individuals in the community.

We heard about how some individuals had been supported by the OT to find a volunteering job and other community activities that they wanted to do, with nursing staff supporting the person attend these. 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. In previous visits, we had been 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. We were reassured on our last visit to see that the budget

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

had been increased and staff confirmed there would be an annual review of this budget. This had not happened since our last visit and we will follow this up with the service.

The physical environment

The Lodge is a Victorian style house that had two large front rooms, one that is a comfortably furnished lounge for individuals which provided a homely communal space, and the other was for staff. The staff room was multi-purpose, where all individual records and medication was stored, along with staff computers. Individuals attended this room for their medication, when they were not self-medicating. There was no separate staff break room.

In the hall area we saw information about advocacy and the Mental Welfare Commission as well as other community resources. The Lodge had a kitchen and laundry room, and we heard from individuals that these facilities had supported their rehabilitation. There was a dining area beside 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. There was no disabled access to the building, and we heard that this had meant a relative who used a wheelchair was unable to visit their relative at the Lodge.

Individuals all had a single room with a wash hand basin. There was one shower room and another shared bathroom. The SCN told us on our last visit that two rooms had new flooring, and the plan was when a person moved on from the Lodge, the vacant room would be decorated before another person was transferred. Unfortunately, this has not been able to happen due to the pressure to admit people quickly when a bed became available. This meant six bedrooms had not been redecorated and still had old, stained carpets, despite being cleaned.

The back stairwell and vestibule area at the backdoor was clearly in need of re-decoration, and the main stairway carpet was stained and loose in places.

The Barron Report, Independent Forensic Mental Health Review: final report 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 there had recently been an annual inspection of the property where issues and concerns were identified, and senior managers had agreed a plan of work with the estates department with a planned timeline for these to happen.

While it was positive to hear that some redecoration had been agreed, we were concerned that there was no agreement to replace the flooring for the main stairs. We were pleased to be updated after our visit that another room had been

redecorated and flooring replaced with a plan for the remaining five rooms to follow suit, as and when individuals were discharged. We were provided with a programme of work, with identified timescales to progress this. We will continue to follow this up with the service.

Summary of recommendations

Recommendation 1:
Managers should ensure that care plan reviews are detailed and provide a summative evaluation of the efficacy of care interventions.

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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