Mental Welfare Commission for Scotland

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

Date of visit: 26 October 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Great Western Lodge ('the Lodge') is part of NHS Grampian's forensic rehabilitation service, and provides single accommodation for eight male patients who are preparing for discharge to the community. The Lodge is situated in a residential setting in the city and all patients are admitted from the Blair Unit in Royal Cornhill Hospital.

The Lodge is a Victorian-style house that provides accommodation over five floors and has no disabled access.

On the day of this visit we wanted to speak with patients, relatives and staff. We also wanted to find out how the unit was implementing the recommendations from the last visit that took place in May 2018. We previously made recommendations in relation to care planning, physical health checks, recording in clinical notes and specified person legislation.

Who we met with

Prior to the visit, we held a virtual meeting with the senior charge nurse (SCN), social work student and clinical nurse manager. We were told that the SCN had recently taken up this post at the Lodge. Contact was also made with the forensic clinical psychologist and forensic consultant psychiatrists.

We met with three patients and reviewed the care of four patients.

We spoke with the SCN, ward staff and clinical nurse manager and also made contact with the local advocacy service that is based at the Royal Cornhill Hospital.

Commission visitors

Tracey Ferguson, social work officer

Lesley Paterson, senior manager (practitioners)

What people told us and what we found

Care, treatment, support and participation

Patients we met with were complimentary about the staff and were positive about their stay at the Lodge. Patients told us that staff were caring, approachable, and were available to talk when needed. Patients described feeling engaged in their care and treatment, telling us they met regularly with their named nurse and consultant psychiatrist, which provided them with the opportunity to discuss any issues. Patients were able to tell us about their rehabilitation plans and the goals that they were working towards. We heard from patients how they enjoyed having their own space, comparing the benefits of the single accommodation at the Lodge compared to the ward environment.

Patients described how the move to the Lodge had helped them with their independence and in their preparation for discharge to the community. Staff told us that each patient was at a different stage of their rehabilitation journey; whilst some patients were quite independent, others required rigorous monitoring and support in supporting their rehabilitation, to ensure progress was maintained.

Nursing care plans

We wanted to follow up on our last recommendation regarding care plans. We saw some evidence of detailed care plans, with regular reviews taking place, however these were variable and inconsistent. Whilst some care plans were person-centred, others appeared generic and lacking in detail, not always identifying each patient's holistic needs.

Although there were regular reviews of the care plans, there were no summative evaluations recorded for these reviews, therefore it was difficult to know where the changes to the care plans had been made, or if the interventions in the care plans were effective in supporting patients to achieve their goals. We would expect that summative evaluations and reviews of individual care plans, including changes made, are clearly recorded in the clinical notes.

Care planning was a recommendation on our last visit, and there appeared to be little improvement in the evaluation of the care plans.

Recommendation 1:
Managers should review their audit processes to improve the quality of care plans and ensure that evaluations of care plans clearly indicate the effectiveness of the interventions being carried out, and any changes required to meet care goals.

The Commission has published a good practice guide on care plans. 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, and can be found at:
https://www.mwcscot.org.uk/node/1203

We wanted to find out how the Lodge had implemented our last recommendation about the recording in clinical notes, of one-to-one sessions with nursing staff. We found good evidence of one-to-one sessions between patients and staff, recorded in the files, along with patient involvement in the care planning, where some had signed the care plans and others refused. Patients told us about the value of these meetings, and were able to tell us who their named

nurse was. Whilst we found regular recordings of the one-to-one sessions, these often described the activity that took place, but did not detail the therapeutic interactions or conversations which took place during these sessions. We had a discussion with the SCN on the day of the visit about how these one-to-one sessions could be detailed in a more meaningful way.

We found helpful checklists in each patient's file, however we found these were not kept up-to-date. We saw some checklists that indicated where the patient did not have an advance statement, some where they did, and another example that noted there was a welfare guardianship order in place, which was not the case. We suggested to the SCN that these checklists should be regularly checked for accuracy.

Multidisciplinary team (MDT)

We were told that MDT meetings take place weekly and the MDT consisted of three consultant psychiatrists, nursing staff, occupational therapy (OT) and forensic clinical psychologists. We were told that the MDT provision was the same for all forensic inpatients, with patients having access to all disciplines throughout their rehabilitation journey. However, on reviewing the files, it was difficult to determine what current OT input patients had. We saw OT assessments that had been completed when the patient was in the Blair unit, however we were told that OT provision across the forensic inpatient services had been limited since the Covid-19 pandemic. We heard that there is no OT in attendance at the weekly MDT, and no ongoing and regular input into the patient rehabilitation plans, often resulting in nursing staff leading on activities. Nursing staff told us that they can still request support from OT for specific pieces of work, but there was no regular input. Managers told us of the ongoing challenges in recruiting OTs across all in-patient services at Royal Cornhill hospital. We will therefore request an update from managers about progress.

The forensic psychologist told us that they were involved in developing the risk formulation plans for all forensic patients, and continue to provide in-house training to all registered nursing staff. Training in RAID (Reinforce Appropriate, Implode Disruptive), a psychological approach for working with challenging behaviour, is provided. Psychology have also delivered training on trauma-informed practice and future plans are to deliver this to the health care support workers across the service.

The forensic service had two psychologists that provide input to patients care and treatment, however we were told that one of the psychologists has recently left post and the service is actively recruiting for a replacement.

In the MDT meeting records there were entries of who attended each meeting, along with a progress update from nursing staff. We were told that patients did not attend this weekly meeting, however the consultant psychiatrist or nursing staff will meet with the patient before or after the meeting. This provided the patient with the opportunity to discuss any issues and patients that we spoke with felt this enabled them to participate in their care and treatment. There was a section in the document that recorded any patient requests, however there was no space on the form to record the outcomes and actions from the meeting. The SCN told us that this had been highlighted during recent audits and the document will be amended. We look forward to seeing this update on our next visit.

Of the patient files we reviewed, we saw detailed risk assessment and risk management plans with evidence of ongoing review. Several patients were subject to Multi-Agency Public Protection Arrangements (MAPPA) and also to the Care Programme Approach (CPA). 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. We were told that these meetings were held on a six-monthly basis and were clearly recorded with timely outputs covering all key areas. We were pleased to see evidence of patient participation at these meetings. The care plans and risk assessments that formed part of the CPA documentation were detailed; we had a further discussion on the day with the managers about ensuring this detail is incorporated into the individual nursing care plans for each patient.

Each patient registers with a GP when they move to the Lodge and all annual physical health checks are undertaken by the GP surgery. Where a patient attends the clozapine clinic, these physical health measures are undertaken at this clinic. Nursing staff provided patients with support to attend these clinics and the outcomes were recorded in their notes and discussed at the MDT meeting as appropriate.

We discussed a patient's physical health care with the SCN and we were told that the Lodge had had to borrow a defibrillator from another service. We are aware that managers plan to source their own as a priority.

Use of mental health and incapacity legislation

Eight patients were subject to detention either under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or Criminal Procedures (Scotland) Act 1995 and we found that the detention paperwork was in order.

Part 16 (s235-248) of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, 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, however we found a few issues with patient's treatment and discussed this with managers on the day and will continue to follow this up.

Recommendation 2:
Managers should ensure that all forms that record treatment are current, authorise all prescribed treatments and are reviewed at the weekly MDT meetings.

Any patient 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 patient had nominated a named person, we would expect to find copies of this in the patient's file. We saw examples where a patient had nominated a named person and also where the named nurse had discussed this, but the patient had opted not make a nomination. We saw that these discussions were also recorded in the CPA documentation.

Rights and restrictions

When we are reviewing patient files we look for copies of advance statements. The term 'advance statement' refers to written statements made under ss274 and 276 of the Mental Health Act, and are 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 saw copies of advance statements in the patient files and this was also recorded on the CPA documentation. It was positive to see that these discussions had taken place, however some documentation wrongly recorded there was no advance statement in place, but yet we found a copy in the file. We discussed this further with the SCN on the day and emphasised the importance of keeping the checklist in the file updated.

The Lodge is permanently open, with no restrictions on access to rooms, and patients have their own keys. The staff keep records of patient's time out of the Lodge, for the purpose of monitoring a patient's suspension of detention, and risk management plans.

Section 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on patients who are detained in hospital. Where a patient 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 are regularly reviewed, along with reasoned opinions to be documented in the files. We wanted to follow up on our previous recommendation in relation to specified person legislation and were pleased to find that where a patient had been made a specified person, all paperwork, including the reasoned opinions were in order.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

The unit had good links with the local advocacy service who are based in the Royal Cornhill hospital. Patients told us about the support they continue to receive from the service and the benefits of the service.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

Many of the patients in the Lodge have spent long periods of time in hospital, which can significantly affects the skills and abilities they need to live in the community. We would expect that an in-patient forensic rehabilitation service would have individualised activities to promote recovery, and to help patients 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 all patients had a weekly planner in place. These planners were not solely activity-based, they also provided the patients with structure and routine for rehabilitation purposes and recorded activity such as shopping, showering and chores. Patients were able

to tell us about their activities and how they were out and about in the community most days. Each patient was at a different stage of their rehabilitation journey, and their planners reflected this. Patients 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 patient meetings to discuss issues, including planning social events. We saw evidence in the patient's notes of the one-to-one activities, and group activities that were supporting patients in the community.

We were aware that during the Covid-19 pandemic, restrictions that were required to be put in place had an impact on various activities out with the Lodge and in the community. The Lodge has a strong emphasis on rehabilitation and supporting patients to move onto the next stage of independent living, however we were told that the pandemic has had an impact on some patient's progress, given that the opportunities were not available in the community to support them on the next step of their journey. We heard from patients that this was a difficult time, as a lot of places were closed and they couldn't get out and about as much; however, they were happy that everywhere was now open.

The Lodge has an activity nurse who also provides input across the three wards in the Blair unit. We were told that the service has recently recruited another activity nurse, and heard of the plans the service has to enhance the delivery of therapeutic provision to patients.

We heard that the OT provision into the unit had been absent for some time, and also of the ongoing challenges in recruiting OT across the services, but were told there had been a Lead OT recently appointed who will review OT provision across all forensic in-patient settings. Staff did tell us that they can still access OT for a specific request, however OT do not routinely work with patients in the Lodge, nor review the patient rehabilitation plans.

Patients told us about the men's group that runs regularly, where specific topics are discussed such as smoking, phone scams, diabetes, and men's health issues. Patients told us of the benefit of these groups and how they had become more knowledgeable, leading to decisions about making positive lifestyle changes. Staff told us about the men's group and we saw positive feedback they had received from patients.

Patients are encouraged to cook for themselves and have individual budget planners in place to support meal planning and shopping. Dependent on their skill level, assistance is provided if necessary. The Lodge recently had a new kitchen installed and there had been some issues with this which limited patient access to cooking facilities. Managers have had to put interim measures in place, however were hopeful of a resolution soon.

The physical environment

The Lodge is a large Victorian house that had two large front rooms; one is a lounge for patients and the other for staff. We were told that the staff room is multi-purpose, in that all the records are stored in this room; staff access computers, medications are stored, meetings take place and patients attend this room to have medication administered or to speak with staff. There was no separate staff break room, however the staff we spoke to did not perceive the lack of a dedicated staff area to be of concern.

There was a large garden to the rear and patients told us that they enjoyed accessing this, particularly in the summer time. Smoking is prohibited in NHS Grampian's grounds and we were told that patients need to smoke outside of the facility. There is a gate that leads out of the back garden to the street.

Patients all have single rooms, with a wash hand basin. There was one shower room and another room with a bath for patients to share. There were water marks on the ceiling in the shower room, that needed further investigating. Some of the seals in the shower room would benefit from re-sealing as the silicone was turning black. One of the toilets was out of use due to ongoing kitchen works, meaning that there were two available toilets for the eight patients.

There were areas in the house, communal and bedrooms, which needed redecoration and upgraded, however we heard from managers that it could be difficult to get work completed, such as bedrooms painted or having old items of broken furniture picked up. We were told that there were annual inspections of the property where issues and works were identified, however these were not carried out. We were disappointed to hear this, particularly as this was an old house will require ongoing upgrading.

Recommendation 3:
Managers should ensure a programme of work, with identified timescales, to address the environmental issues and outstanding repair and refurbishment work.

It was good to see the newly installed kitchen that had recently been completed, which patients will greatly benefit from. Unfortunately the installation has impacted on the water supply and this was being worked on during our visit.

The Independent Review into the Delivery of Forensic Mental Health Services that was published in February 2021 made recommendations regarding the physical environment of forensic services and that Health Boards required to address these issues. As Great Western Lodge is part of the forensic pathway, we will continue to seek updates from NHS Grampian about their pathway and future provision.

Summary of recommendations

Recommendation 1:
Managers should review their audit processes to improve the quality of care plans and ensure that evaluations of care plans clearly indicate the effectiveness of the interventions being carried out, and any changes required to meet care goals.

Recommendation 2:
Managers should ensure that all forms that record treatment are current, authorise all prescribed treatments and are reviewed at the weekly MDT meetings.

Recommendation 3:
Managers should ensure 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 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.

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 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.

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