Mental Welfare Commission for Scotland

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

Date of visit: 21 November 2023

Where we visited

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 were admitted from the Blair Unit in Royal Cornhill Hospital. The Lodge is an old Victorian-style house that provides accommodation over five floors, and had no disabled access.

We last visited the Lodge in October 2022 and made recommendations about care planning, treatment certificates and the environment. We received an action plan from the service and were satisfied as to how the service had planned to address the recommendations.

On the day of this visit, we wanted to follow up on the previous recommendations and speak with individuals, relatives, and staff.

Who we met with

When we plan a visit, prior notice is given to individuals and relatives of our intention to visit. Given that this visit was unannounced, we were unsure if we would have the opportunity to speak with individuals and relatives. Throughout the day we introduced ourselves to most individuals that resided at the Lodge and further met with two individuals and reviewed the care and treatment of four.

We spoke with the senior charge nurse (SCN) and other nursing staff.

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

Staff told us that they knew the individuals well prior to their move to the Lodge as all individuals have come through the forensic pathway, and the staffing team in the Lodge have the opportunity to work across all of the forensic wards in the Blair Unit.

Staff told us that each individual was at a different stage of their rehabilitation journey. Where some individuals had recently moved to the Lodge, others had remained at the Lodge since our last visit. We heard how some individuals were quite independent and others required rigorous monitoring and support to aid their rehabilitation, and to ensure progress was maintained. 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 individuals was positive about their stay in the Lodge. Individuals told us that nursing staff were available to talk when they needed to and that they had regular one-to-one sessions with staff, either in the Lodge or out in the community. Individuals described feeling engaged in their care and treatment and told us about the opportunities they had to discuss their care and treatment with their consultant psychiatrist and nursing staff.

Those that we spoke with were able to tell us about their rehabilitation plans and of the involvement of the multi-agency professionals that supported them to meet their goals. We heard how they enjoyed having their own space, and how the move to the Lodge aided their recovery. Individuals were aware of their rights and told us about their involvement with advocacy services to support them with these. We heard from one individual that they wanted to move on and were dissatisfied about the length of time this has taken.

Nursing care plans

The care plans were in paper format and we found it easy to navigate an individual's files. We wanted to follow up on our last recommendation regarding care planning to see what progress had been made.

The SCN told us about the piloting of the new care plan documentation that had come from a working group that had been devised to improve care planning documentation and processes across all of NHS Grampian. We saw the new documentation and were aware that the nursing staff were in the process of changing over all the care plans to this; we were pleased to note improvement in this area as we reviewed the files.

We saw some detailed, comprehensive care plans, with regular reviews taking place that had evidence of individuals' participation, apart from one file where there were no care plans in place. We were made aware that the individual had transferred to the Lodge five weeks earlier, and we were of the opinion that there should have been a care plan put in place by this time. We raised this with the SCN, who agreed and advised that this would be attended to. The care plans we did see covered a wide range of needs and were detailed and goal-focussed. We saw that some individuals had signed their care pans, whilst others wished not to, and that nursing staff had recorded this on the care plan, which was positive. Another improvement that we noted was when we spoke with individuals, who told us they were aware of their care plans and had seen them. We were made aware that there had also been a new care plan evaluation

form devised, however, as many of the care plans had recently been transferred to the new document, some care plans were not at the stage of requiring evaluation. The SCN also told us that a new audit form has been devised which was being trialled this month. The outcomes of this will be taken back to the working group to see if further changes are required, before the documentation is rolled out.

We were pleased with the work that had been done since our last visit around the care planning process and documentation, and we hope that having a robust audit tool in place will ensure that there is a consistent standard maintained across the care plans in the Lodge; we look forward to reviewing this on our next visit.

We found evidence of regular one-to-one sessions between individuals and staff, recorded in the files that were detailed and meaningful, as were the daily nursing entries recorded in the notes.

Multidisciplinary team (MDT)

We were told that the MDT meetings continue to take place weekly and consist of three consultant psychiatrists, nursing staff, occupational therapy (OT), forensic clinical psychologist, along with input from pharmacy. We were told that social workers and mental health officers also attended the MDT meeting, but not every week. We heard that the MDT provision was the same for all individuals across the forensic wards, and all had access to the full range of disciplines throughout their rehabilitation journey. We heard that since our last visit, input from OT has increased and we were pleased to hear this, but also aware that there continued to be ongoing challenges recruiting OTs across all inpatient services at Royal Cornhill Hospital and in the community; the forensic service still had a vacant band 7 OT post.

We heard last year that the forensic service had two psychologists that provided input to individuals' care and treatment, and how one had left the service, although we were pleased to hear that the service had recently recruited to the other vacant post.

The MDT document records who attends the meeting, along with a progress update from nursing staff, and we found that most detailed. We were told that individuals did not attend this weekly meeting however, the nursing staff met with the individual before the meeting to see if they had any specific requests for discussion, and then provided feedback to the individual following the meeting. We were told that everyone met with their consultant psychiatrist regularly, which is what individuals told us and we saw evidence of this from reviewing the files. This meeting provided individuals with the opportunity to discuss any issues and enabled them to participate in their care and treatment.

Of the individual files we reviewed, we saw detailed risk assessment and risk management plans with evidence of regular review, and where individuals were subject to Multi Agency Public Protection Arrangements (MAPPA), we found this documentation in the files. The forensic psychologist continued to be involved in undertaking HCR-20 risk assessments, developing the risk formulation and risk management plans for all forensic patients; we found evidence of this in the files.

All individuals were subject to the Care Programme Approach (CPA) and we found minutes of these meetings in the file. 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 regularly, depending on where the individual was in their rehabilitation journey, however they would be held no less frequently than six monthly. We saw where some individuals who were nearing discharge had three monthly meetings, along with additional discharge planning meetings incorporated into their care and treatment.

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.

Each person is registered with a GP when they move to the Lodge and all annual physical health checks are undertaken by the GP surgery. Where an individual attends the clozapine clinic, all specific checks are undertaken there. Nursing staff provided support to individuals with appointments and updates were brought back to the MDT. We found that there was a good level of detail with regards to physical health checks and there was an emphasis on health living and healthy eating at the Lodge.

Use of mental health and incapacity legislation

All individuals in the Lodge were subject to detention under either 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.

We wanted to follow up on our recommendation from last year's visit where we found that treatment was being given out with authority of the Mental Health Act. Part 16 (sections 235-248) of the Mental Health Act sets out the conditions under which treatment may be given to individuals who are detained and 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 and easy to locate. We were told that the treatment certificates were reviewed and checked in accordance with each individual's prescription at each MDT meeting and we saw that the MDT meeting documentation now incorporates a section on treatment certificates.

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 an individual had nominated a named person, we would expect to find copies of this in the file. We saw examples where a named person had been nominated. This information was easy to find and clearly recorded.

Rights and restrictions

The term 'advance statement' refers to written statements made under sections 274 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 files, we look for copies of them. Where

individuals had chosen to complete an advance statement, we found copies in individual files, this information was also recorded on the CPA documentation.

The Lodge is permanently open with no restrictions on access to rooms and individuals have their own keys. The staff keep a record when an individual has time out of the Lodge, for the monitoring purposes of suspension plans, and this is 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 files. We found that where an individual had been made a specified person that all paperwork, including the reasoned opinion, was in order.

The Lodge had good links with the local advocacy service who were based in the Royal Cornhill Hospital and on reviewing files and in speaking to individuals, we noted that they valued the support they received from 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.

Activity and occupation

Individuals in the Lodge have spent long periods of time in hospital, which has significantly impacted on skills and abilities that are needed to live back in the community. We would expect that an inpatient forensic rehabilitation service would have individualised activities to promote recovery, which would help individuals gain or regain the skills and confidence needed to progress their recovery.

The Lodge had access to two activity nurses who also provided input across the three wards in the Blair Unit, enhancing the delivery of therapeutic provision to individuals.

We heard about social outings in place, and that the lodge had residents' meetings to discuss issues, including planning social events. We saw evidence in individual files 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. The planners were not solely activity-based, but provided the individual with structure and routine for rehabilitation purposes, such as shopping, cooking, showering and cleaning. Each planner reflected where the individual was in their rehabilitation journey. 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. 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 planning and progress that would be required to get to that next stage.

We were told that all individuals in the Lodge were encouraged to cook for themselves according to their skills ability, with assistance provided if needed, and that everyone was allocated a weekly catering budget of £31. The SCN told us that everyone was expected to purchase 14 meals per week from this budget (seven lunches and seven dinners) however, we were told that due to rising food costs, that the budget was no longer sustainable and staff provided us with examples of where the catering money for some individuals had run out before their next payment, which meant that staff had to intervene. The SCN told us that senior managers had been alerted to this and we were concerned to hear about this, particularly as these individuals were in hospital being supported to progress to the community, and even in this situation had found themselves at times running out of food and money.

Recommendation 1:
Managers must review the current weekly catering budget that is awarded to individuals residing in Great Western Lodge to ensure it is sufficient for individuals to purchase adequate food for their lunches and dinners.

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

The lodge had a new kitchen installed last year and we heard how this facility had been of benefit to individuals' rehabilitation. Individuals told us that they enjoyed cooking their own meals and sometimes a group meal. 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. There were water marks on the ceiling in the shower room that were there on our visit last year. We had highlighted then that some of the seals in the shower room would benefit from re-sealing, as the silicone was starting to go black, however this was still the same. We wanted to find out about our last recommendation as we were told that there was a programme of works planned.

The SCN told us that new furniture had been bought for the sitting and dining area and new carpets and flooring had been fitted in some bedroom and communal areas. We were able to see that there had been some redecoration works completed and other areas where works had been identified but were still outstanding. 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. We were pleased to see that some progress had been achieved with décor but were aware that due to the style and age of the house, the environment will require ongoing upgrading, and a continuous programme of

works that ensures the health, safety and wellbeing of the individuals and staff who reside and work at the Lodge is put in place.

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 were 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 future provision across all forensic wards.

Summary of recommendations

Recommendation 1:
Managers must review the current weekly catering budget that is awarded to individuals residing in Great Western Lodge to ensure it is sufficient for individuals to purchase adequate food for their lunches and dinners.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the publication 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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