



**Mental Welfare Commission for Scotland**

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

**Date of visit:** 2 May 2018

## **Where we visited**

Great Western Lodge is a rehabilitation unit situated in a house which, though part of the Royal Cornhill Hospital service, is located in a residential setting in the city. It offers intermediary beds for eight men, all of whom had been admitted from the Blair Unit at the main hospital. All rooms are single accommodation for patients, and are on the upper floors of the building with no disability access. We last visited this service on 29 November 2016 as part of a national themed visit programme to low and medium secure forensic wards. Our last local focussed visit was on 7 April 2016. The recommendations following these visits were in relation to: care plans; one-to-one meetings with named nurse; advance statements; and physical health checks. On the day of this visit we wanted to follow up on previous recommendations and look at how changes were being implemented. There was some evidence of advocacy being promoted and we left copies of the Mental Welfare Commission's patient rights pathway documents for patients and staff.

## **Who we met with**

We met with and/or reviewed the care and treatment of seven patients.

We spoke with the deputy charge nurse and other clinical staff.

## **Commission visitors**

Douglas Seath, Nursing Officer

Paula John, Social Work Officer

## **What people told us and what we found**

### **Care, treatment, support and participation**

On the visit, we found that the staff knew their patients well and it was clear that there was a good relationship between those who lived there and staff providing the support. The emphasis in the unit was on encouraging patients to shop, attend placements and take part in other activities within the local area, with the goal of moving to placements providing a greater degree of independence. We were pleased to see that a number of patients had advance statements recorded in their files and that most of the patients were on self-medication programmes.

Risk assessment and safety plans were present for each patient and were very thorough. Several patients were subject to Multi Agency Public Protection Arrangements and also to the Care Programme Approach. Overall, we found that nursing care plans were variable and inconsistent. Some plans did identify the nature of the individual's needs and preferences but, in a number of cases, plans were very generic. These did not contain appropriate person-centred information, lacking the detail required. For instance, for one patient, in response to signs of distress, nurses

were instructed to intervene and use distraction techniques. However, these were not specified. Similarly, where side effects of medication were to be monitored, it would be more helpful to list what these might be. Moreover, the evaluation of care plans was inconsistent and present in very few of the care plans examined.

There was a named nurse system in place but it was not clear how this worked. Although there is a named nurse for each patient, patients did not meet them on a regular basis nor was there a record of meetings to evaluate care. We would expect that summative evaluation and review of individual care plans, including changes made, should be documented with the care plan in the notes.

Specific documentation was used to record the multidisciplinary team reviews, and these reviews were clear and detailed. Meetings were held weekly and there was clear evidence of input from a team that included doctors, nurses, occupational therapists, psychologists and social workers, mostly of whom were mental health officers.

Specialist services were available with many staff e.g. occupational therapy, pharmacy, physiotherapy in regular attendance and attending reviews.

Some patients had been there a long time and, due to their complex needs, proved difficult to rehabilitate to an environment requiring less support. However, efforts had clearly been made to initiate rehabilitation programmes and review progress, unfortunately without success.

Documentation of physical health checks, reported to have been carried out, was difficult to locate in records.

**Recommendation 1:**

Managers should ensure that care plans contain specific interventions and evaluation clearly documented in order to ensure consistency of nursing input.

**Recommendation 2:**

Managers should ensure that patient one-to-one sessions with nursing staff are recorded and, where participation is declined, that this is noted.

**Recommendation 3:**

Managers should ensure that documentation of the annual physical health review is routinely filed in the patient's case notes

## **Use of mental health and incapacity legislation**

All of the patients in the unit were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act 1995.

Documentation was present and well ordered. Consent to medical treatment forms, T2 and T3 under s240 of the Mental Health Act, were also present and located with the drug prescriptions.

## **Rights and restrictions**

The unit is permanently open with no restrictions on access to rooms and patients have their own keys.

Patients designated as specified persons under s281-286 of the Mental Health Act had up to date forms completed together with reasoned opinions. Although many of the restrictions appeared appropriate to identified risk, it was evident that in most cases the restrictions were not necessary and interventions were not being carried out.

### **Recommendation 4:**

Managers should ensure in terms of the principle of least restriction, specified persons forms should be reviewed by the responsible medical officer to determine if they continue to be necessary.

## **Activity and occupation**

There was a strong emphasis on rehabilitation, supporting individuals referred from the hospital ward environment into Great Western Lodge and on into independent living. We found good evidence of nursing staff and occupational therapists providing a range of inputs, including skills development and facilitating activities both on and off the unit. Within the service, groups are offered on topics such as moving on from hospital, completing a curriculum vitae and information about substance misuse.

Each patient was encouraged to budget and cook for themselves, according to their skills level, with assistance provided if necessary. Activities were many and varied with programmes designed around rehabilitation. Some individuals had work placements, others attended college or participated in voluntary work placements. There were also social outings both escorted and unescorted to give patients opportunities to develop skills in this area and to expand their social networks prior to discharge.

## **The physical environment**

The ward was in fairly good decorative order, though some of the furniture was a little outdated. Some attempts had been made to improve the environment, with a room now available with a console and large screen for computer games.

The kitchen appeared well provided, and was also clean and tidy with storage space in cupboards and fridge for each patient.

There was a large garden to the rear and smoking was prohibited in the house and environs. This has resulted in ongoing complaints from neighbours about patients smoking out in the street.

## **Summary of recommendations**

1. Managers should ensure that care plans contain specific interventions and evaluation clearly documented in order to ensure consistency of nursing input.
2. Managers should ensure that patient one-to-one sessions with nursing staff are recorded and, where participation is declined, that this is noted.
3. Managers should ensure that documentation of the annual physical health review is routinely filed in the patient's case notes
4. Managers should ensure, in terms of the principle of least restriction, specified persons forms should be reviewed by the responsible medical officer to determine if they continue to be necessary.

## **Good practice**

We heard about two examples of good practice where additional funds were obtained via Self Directed Support to aid with employing support staff to engage in emotional support and befriending of patients.

Also, future placements in terms of supported accommodation were taken to a centralised forum by social work staff, where allocations were made dependent on needs of individuals.

## **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.

Alison Thomson  
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 MWC is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors. Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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