**Mental Welfare Commission for Scotland**

**Report on announced visit to:** Graham Anderson House, 1161 Springburn Road, Glasgow, G21 1UU

**Date of visit:** 10 June 2021

## Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's Route Map (May 2020). There have however been periods during the pandemic where we have been able to conduct our face-to-face visits. This local visit was able to be carried out face-to-face.

Graham Anderson House is an independent, specialist, 25-bedded, mixed sex assessment and rehabilitation service for people with a non-progressive acquired brain injury, regulated by Healthcare Improvement Scotland (HIS). It forms part of the network of specialist rehabilitation centres provided by the Brain Injury Rehabilitation Trust, a charity which runs a network of specialist centres across the UK. The main hospital building has 21 beds: 15 acute neuro-rehabilitation beds in Watten Ward, five beds for patients with complex behavioural needs who require more intensive rehabilitation in Earn Ward, and a one-bedroom flat to support individuals as they transition from hospital. Heather Ward is a four-bedded bungalow for more independent patients and is classed as an extension of the hospital. On the day of our visit there were 16 patients within the service and nine empty beds.

There is also a newer facility adjacent to the main hospital building called Eastfields. It provides care for individuals who continue to need specialist support, but no longer require this in an acute setting. It is designated as a community care facility and as such, is regulated by the Care Inspectorate. We did not visit Eastfields on the day of the visit.

We last visited Graham Anderson House on 2 October 2018 and made recommendations related to patients' rights, advanced statements, and delayed discharges.

On the day of this visit we wanted to follow up on the previous recommendations and also find out how the service had managed throughout the current Covid-19 pandemic, specifically in relation to the impact of restrictions, contact with relatives, reductions in opportunities for rehabilitative activities outwith the ward, and on the mental health of patients. We also wanted to give patients an opportunity to raise any issues with us and to ensure the care, treatment and facilities are meeting patients' needs. We had recently been involved in a case of a significantly delayed discharge and. although there has been a positive resolution, we wanted to follow this up.

## Who we met with

We met with and reviewed the care and treatment of eight patients and spoke with the service manager, nursing staff, occupational therapy (OT) staff, support staff and administrative staff.

## Commission visitors

Lesley Paterson, Nursing Officer
Mary Hattie, Nursing Officer
Dr Gordon Skilling, Consultant Psychiatrist
Kathleen Taylor, Engagement and Participation Officer (Carers)

# What people told us and what we found

## Care, treatment, support and participation

Patient feedback was positive. The patients described an atmosphere where staff were readily available, supportive, caring and always willing to spend time talking with them. They described the accommodation as comfortable, the food as being of a high quality and reported no concerns about the care and treatment provision.

The care plans we checked in patient files were of a high quality. They were comprehensive, patient-centred, detailed and demonstrated a great deal of patient involvement. They were regularly reviewed and there was a clear focus on rehabilitation.

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/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

The psychology led rehabilitation model of care at Graham Anderson House means psychologists provide extensive input to the patients' care. The consultant clinical neuropsychologist provides clinical leadership for the service and has only recently been recruited. They are due to commence the post in August 2021. There is a part-time consultant psychiatrist (Responsible Medical Officer) who attends the service a minimum of one day per week; however they are contactable out with this time. Each patient is medically reviewed at least fortnightly, but more frequent review occurs if requested by either patients or staff. There is significant input from other disciplines including (OT), speech and language therapy and physiotherapy who provide a wide range of multidisciplinary care.

Multidisciplinary meetings take place weekly, along with professionals meetings which consider referrals to the service and pre-admission assessments. There was good detail within the notes regarding who attended each meeting, discussions, outcomes and actions. There was evidence of patient involvement and full multidisciplinary input. Risk assessments were robust, as were risk management plans and there was a clear link between risk, care, and treatment.

There is a service level agreement in place that ensures a visiting GP service provides two sessions per week. All annual health checks are carried out along with any other required monitoring including bloods for Clozapine therapy, lithium therapy, high dose antipsychotic monitoring and diabetic monitoring. There was evidence in the care records that physical health care was high on the clinical agenda. The ward has significant input from occupational therapy and physiotherapy and referrals are made to dietetics, podiatry and speech and language therapy if required. Pharmacy staff are available for consultation if and when required.

The Advocacy Project provide an advocacy service to Graham Anderson House and we heard from both patients and staff that this is easily accessible and patients find it helpful. There

were multiple sources of information available for patients, including leaflets, notice boards and laminated posters on bedroom walls on subjects such as: Advocacy, Duty of Candour, Confidentiality and Carers, Patient Rights and Responsibilities. These were also available in easy read formats, which is essential given that many patients have communication difficulties and/or cognitive impairments.

There was a regular communication group which patients find helpful as they feel involved and consulted on a wide range of issues and prior to the Covid-19 pandemic; there was a regular carers group. The service hope to start the latter again soon. It was evident from the chronological notes and from talking to nursing staff that they actively promote and support family involvement in the patient's life and, where appropriate, in discussion of the patient's care and treatment. A significant issue for patients and families across Scotland has been maintaining contact during the Covid-19 pandemic due to national restrictions on hospital visiting. Graham Anderson House staff have prioritised family contact and although the majority of visiting has been taking place over the telephone or by video call, visiting sessions in the hospital grounds have been supported and visiting guidelines will continue to be reviewed in line with current Scottish Government guidance.

The service previously had a significant number of delayed discharges; however we were pleased to hear there has been improvement in this area. The development of the Eastfields service means three of the four patients who are currently on this delayed list will soon be moving there and one will be returning to a facility within his home health board later this month.

## Therapeutic Activity and occupation

Every file we reviewed contained comprehensive OT functional assessments, reviews, structured activity planner, weekly activity programmes and activity based care and treatment plans. There are a wide range of multidisciplinary led activities taking place in the service including meal preparation and cooking groups, art and crafts groups, quizzes, dominoes, bingo, beauty sessions, pool, ten-pin bowling, socialisation through games and weekly themed nights.

Many of the activities had a rehabilitation focus such as the 'cardio wall' which is used to develop motor skills, visual scanning and hand eye coordination and the 'Coffee Crew' which is a group chat over coffee which sometimes uses 'Let's Talk' cards aimed at enhancing social communication skills with suggested conversation starters. There were activities which aimed to improve the ability to carry out activities of daily living and household chores such as laundry, vacuuming, cleaning windows and vocational activities including woodwork, painting and gardening.

The service has a rabbit hutch with two rabbits in one of the garden areas. Some of the patients enjoy tending and caring for the rabbits. Prior to the Covid-19 pandemic there was a large focus on patient activity outings and sourcing appropriate external placements. We were told both these activities will resume as we emerge from the pandemic.

## Use of mental health and incapacity legislation

Eleven of the 16 patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') or the Criminal Procedure (Scotland) Act 1995. Anyone who receives treatment under the Mental Health Act can choose someone to help protect their interests. That person is called a named person. Where patients wanted to nominate a named person we saw records of this in the patients file.

Part 16 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. Unfortunately consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were not all in place where required, meaning there were instances where psychotropic medication was being given without the legal authority to do so. We were however pleased to see that all section 47 certificates, treatment plans and spending plans under the Adults with Incapacity (Scotland) Act 2000 were in place where required.

S281 to 286 of the Mental Health Act provide a framework within which restrictions can be placed on people 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. It was apparent from discussion with some staff and from looking at care records that there appears to be a lack of understanding about specified person legislation and in some cases there was little evidence of review or a record of reasoned opinion to explain the rationale for application of the legislation. The Commission expects all restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed.

Our specified persons good practice guidance is available on our website.

http://www.mwcscot.org.uk/media/216057/specified_persons_guidance_2015.pdf

### Recommendation 1:

Managers should ensure that all psychotropic medication is legally and appropriately authorised on either a T2 or T3 form and a system of regularly auditing compliance with this should be put in place.

### Recommendation 2:

Managers should ensure specified persons procedures are implemented for patients where this is required to authorise room searches or other restrictions and all staff are clear on these processes and legislation.

## The physical environment

The units were welcoming, bright, clean, and tidy. Each patient had a large en suite bedroom which they had personalised to their own taste. The common areas were bright and spacious. There were large internal courtyards and gardens which were spacious and well maintained. The units were pleasantly decorated and it was pleasing to see so much of the patients' artwork on display. There was a real feel of inclusiveness and the patients were proud to point out projects they had completed.

## Any other comments

Although the Covid-19 situation has been a devastating and traumatic time, it has presented challenges that have required collaboration, commitment and finding new ways of working. We were impressed with the way in which the service has worked hard to be creative, flexible and adapt to best meet the needs of the patients and this view was echoed by both patients and staff we spoke to. It is hoped the positive changes that have benefitted some aspects of patient care can be continued and developed in future models of care.

After the visit had taken place we were contacted by the service highlighting that due to a combination of reasons, they were currently having difficulty in accessing independent second medical opinions / reports required to complete some Mental Health Act detentions and there was concern that Mental Health Act orders may expire as the application could not be completed in advance of the current order expiring. This did cause concern, however managers have since discussed with us how they plan to rectify the situation.

**Recommendation 3:**

Managers should inform the Commission of how they have ensured access to independent medical practitioners for the timeous completion of the second opinion medical reports, required for Mental Health Act detentions.

## Summary of recommendations

1. Managers should ensure that all psychotropic medication is legally and appropriately authorised on either a T2 or T3 form and a system of regularly auditing compliance with this should be put in place.

2. Managers should ensure specified persons procedures are implemented for patients where this is required to authorise room searches or other restrictions and all staff are clear on these processes and legislation.

3. Managers should inform the Commission of how they have ensured access to independent medical practitioners for the timeous completion of the second opinion medical reports, required for Mental Health Act detentions.

### 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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