Mental Welfare Commission for Scotland

Report on announced visit to:

Graham Anderson House, 1161 Springburn Road, Glasgow, G21 1UU

Date of visit: 21 February 2023

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.

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 25 beds: 19 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 19 patients, nine of whom were detained under the Mental Health (Care & Treatment) (Scotland) Act 2003.

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 this service on 10 June 2021and made recommendations in regard to consent to treatment documentation, specified persons and access to medical practitioners for second opinion assessments as required.

The response we received from the service was that all of the recommendations had been addressed and that they no longer had any outstanding issues regarding the recommendations.

On the day of this visit we wanted to follow up on the previous recommendations and also to look at how activities had been reintroduced following the pandemic restrictions as well as finding out how patients and relatives are included in care planning and decisions. This is because we had heard from some relatives that communication had not been at it's best with them.

Who we met with

We met with, and reviewed the care of 13 patients, 10 who we met with in person and three who we reviewed the care notes of. We also spoke with two relatives.

We spoke with the manager, the assistant manger, the admission and discharge co-ordinator and the Lead clinical psychologist.

Commission visitors

Margo Fyfe, senior manager
Douglas Seath, nursing officer
Anne Craig, social work officer
Gordon McNelis, nursing officer

What people told us and what we found

Care, treatment, support and participation

As at the time of our last visit to the service, the patients we met with were positive about their care, treatment and overall support. The patients described staff as approachable and always available to them. Statements were made such as “lovely, really helpful” and “always around when you need to talk”. Everyone complimented the environment and similar to our last visit, patients were complimentary about the standard of food.

Throughout the visit we saw kind and caring interactions between staff and patients. Staff that we spoke with knew the patient group well. One member of staff we met had an outstanding knowledge of the systems and how the service as a whole works. We were informed by the manager that this staff member is currently carrying out multiple roles and is integral to the functioning of the hospital. We were concerned that the service relies on one individual so heavily and suggested reviewing workloads and roles to ensure the responsibility is spread and that the roles are formally acknowledged.

Multidisciplinary team

Graham Anderson House has a psychology-led model of care. This means that psychologists provide the mainstay of the rehabilitation model of care for the patients. There is a consultant clinical neuropsychologist who provides clinical leadership for the service. There is also 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 also input from other disciplines including occupational therapy (OT), speech and language therapy (SLT) and physiotherapy who provide a wide range of care.

Multidisciplinary (MDT) meetings take place weekly, alongside professionals meetings which consider referrals to the service and pre-admission assessments. All detained patients are reviewed by the consultant psychiatrist weekly. There was evidence of patient involvement in these meetings if they wished. Meeting notes were held on a separate electronic system from the patient electronic record and actions from the meetings were emailed directly to team leaders for each ward to be carried out. We were concerned that the full meeting note was not available on the individual patient record as this would mean that the full discussion is not available to staff that provided direct care. We suggested that it would be helpful to have the minute from each individual’s discussion added to their electronic record for ease of access by all staff that provided care, and to ensure information is not lost or overlooked.

Risk assessments were done on a traffic light system and regularly reviewed. These assessments correlated with patient needs and MDT meeting discussions.

It was good to see that there was still a service level agreement in place that ensured a visiting GP service provided two sessions per week. We saw evidence of annual health checks being carried out. We saw good attention to physical health care needs. Access to wider disciplines is by referral and we noted no issues in service provision as needed. We heard that the service are in the process of changing from a local pharmacy service to an English service that will

provide stringent governance that they feel would beneficial for them going forward. We look forward to hearing more about this when we next visit.

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. We saw a lot of information available to patients on services. The information was provided by leaflets, notice boards and laminated posters on bedroom walls, covering subjects such as: advocacy, duty of candour, confidentiality and carers, patient rights and responsibilities. These were also available in easy read formats, which was essential given that many patients had communication difficulties and/or cognitive impairments.

Carers

When we last visited we commented that it was evident from the chronological notes, and from talking to nursing staff that they had actively promoted and supported family involvement in each patient's life and, where appropriate, in discussion of the patient's care and treatment. Again we saw evidence of this in patient records that we reviewed. However, on speaking to relatives prior to our visit, we were told that it can be difficult to get the information they want and to feel listened to at times. We would be keen to hear more about efforts to involve and support families when we next visit as we were of the view that families can offer a richness of information on individuals when they are not in a position to do so for themselves.

Care plans

We found care plans to be detailed and person-centred. There was evidence that patients were involved in care planning and it was good to see that easy read versions were available for use in discussing the plans with the patients. We suggested it may be helpful for the patients to have a copy of the easy read version of their care plan in their rooms, to help with recall and understanding of the reasons for their admission to the hospital.

We were disappointed to see poor care plan reviews. Although reviews appear to be have been happening and staff that we spoke with clearly knew the patients well, we could not source written evidence of reviews. We discussed with managers the importance of meaningful care plan reviews and our expectation that these should be easy to find in patients' records.

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

Recommendation 1:
Managers should ensure that staff carry out regular meaningful reviews of care plans, that patients are involved in reviews and can access the care plans and reviews as they wish.

Delayed discharges

Previously the service had a significant number of delayed discharges. On this occasion we heard that this had significantly decreased, and there were only two patients awaiting appropriate placement and care packages. We heard that these are being worked on and that it is hoped placements will be found soon.

Care records

Information on patients care and treatment was held on a new electronic record system, My Plan, and multidisciplinary meeting notes were stored on another electronic system. Until recently, all records were on a paper format and we heard that staff were just getting used to the new system. We found this confusing. There was no indication of where specific pieces of information were located. We were of the view that this could lead to a risk of information going missing. We discussed this on the day of the visit and were assured that discussions are ongoing with the IT department to ensure that going forward, most information can be saved to the one system. We look forward to seeing how this progresses when we next visit.

Use of mental health and incapacity legislation

On the day of our visit, nine of the 19 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). 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 a patient wanted to nominate a named person, we saw a record of this in the patient's file.

All documentation pertaining to the Mental Health Act and Adults with Incapacity (Scotland) Act 2000 (AWI), including certificates around capacity to consent to treatment, were in place in the paper files held in the main duty room and were up-to-date.

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. When we last visitied we found that the 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 pleased to see that for this visit, all such documentation was in place giving appropriate authorisation for the medication prescribed. We were also pleased to see that all section 47 certificates, treatment plans and spending plans under AWI were in place where required.

Rights and restrictions

Graham Anderson House operated a locked door, commensurate with the level of risk identified in the patient group.

S281 to 286 of the Mental Health Act provide a framework in 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. When we last visited we raised concerns that staff did not fully understand this part of the legislation. At the time, we highlighted that the Commission expected all restrictions to be legally authorised and that the need for specific restrictions was regularly reviewed. We were pleased to see that all documentation pertaining to specified persons was in place where required, and that there was an overall clearer understanding of specified persons.

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

Therapeutic activity and occupation

When we last visited every file we reviewed contained comprehensive occupational therapy (OT) functional assessments, reviews, structured activity planner, weekly activity programmes and activity based care and treatment plans. On this occasion some of that information was still being transferred over to the new electronic record system and we had to ask to see individual pieces of information. We were assured by managers that all records will continue to be transferred and should all be in place when we next visit the service. We look forward to seeing this.

Now that restrictions are beginning to lift and patients are once again able to resume community activities, they were again having to adapt and cope with the changes in routine that this has brought to them. We heard that staff had gone the extra mile to facilitate activity and ensure patients' needs in this area were met. We were pleased to see a wide range of multidisciplinary led activities taking place in the service, including activities of daily living, art and crafts groups, quizzes, dominoes, socialisation through games and weekly themed nights. There were many activities that focused on rehabilitation and we were pleased to see a well-equipped gym that patients used under physiotherapy supervision. It was good to hear about the focus on patient outings and the sourcing of appropriate external placements. Patients that met with us told us how much they valued this part of their care.

The physical environment

As at the time of our last visit, we found the units to be 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. The only concern about the environment was that it was very hot. We were told this was down to the type of heating and that they were constantly trying to ensure heating was optimal for the patients group.

Summary of recommendations

Recommendation 1:
Managers should ensure that staff carry out regular meaningful reviews of care plans, that patients are involved in reviews and can access the care plans and reviews as they wish.

Service response to recommendations

The Commission requires a response to this recommendation 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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk