Mental Welfare Commission for Scotland

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

Date of visit: 2 October 2018

Where we visited

Graham Anderson House is an independent specialist assessment and rehabilitation service for people with a non-progressive acquired brain injury. 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: 24 beds across three wards (Earn, Lomond, and Ness) and a one-bedroom flat to support individuals as they transition from hospital. Lomond and Ness are adjacent, mixed-sex wards, providing 19 acute neuro-rehabilitation beds. Earn is a five-bed unit for patients with complex behavioural needs who require more intensive care and support.

Eastfields is a newer facility adjacent to the main hospital building. It provides care for individuals who continue to need specialist support, but no longer require this in an acute setting. Eastfields has four units, each accommodating four residents. Heather Ward is classed as an extension of the hospital for more independent patients. Like the main hospital, it is regulated by Healthcare Improvement Scotland (HIS). The other three units are designated as community care facilities. As such, they are regulated by the Care Inspectorate. These comprise two supported living units, each housing four independent flats, and Bluebell, a four bed unit providing long-term specialist nursing care.

We last visited this service on 23 January 2017 and made recommendations related to capacity to consent, documentation, access to advocacy, and delayed discharge.

On the day of this visit we wanted to follow up on the previous recommendations and also look at the legal framework for transfer of patients on discharge. This is because we have been contacted about this by other agencies.

Who we met with

We met with and/or reviewed the care and treatment of 12 patients. We spoke to the relatives of one patient on the day of the visit, and we spoke by phone with two patients' relatives on the days around the visit who had contacted us as they were unable to attend on the day of the visit.

We spoke with the service manager and the head of care on the day of the visit.

In addition we spoke by phone with the advocacy service that works with the facility.

Commission visitors

Ritchie Scott, Medical Officer

Mary Hattie, Nursing Officer

Mary Leroy, Nursing Officer

Yvonne Bennett, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

Patient feedback was largely positive. The patients described an atmosphere with ready access to staff support and a caring attitude.

Care

Care plans we checked in patient files were of a high quality. These were comprehensive and covered individual needs well. These were person centred in nature and were in a SMART format. The care plans showed a good focus on rehabilitation. There was good evidence of carer involvement in setting care plan goals.

The rehabilitation model of care is led by psychology. who provide extensive input to the patients' care. Psychiatry review of patients occurs at least fortnightly, but more frequent review occurs if requested by either patients or staff. There is a wide range of input from other disciplines including occupational therapy, speech and language therapy, physiotherapy and so on, providing a wide range of multidisciplinary care.

There was very clear care planning around the use of 'as required' medication that gave detailed instruction on behavioural interventions to be used to try to prevent medication use and the thresholds for using this.

Participation

In view of the issues around advocacy raised at the last visit, we enquired carefully about this in patient interviews. The patients we spoke to had all accessed advocacy and had found this helpful. We had not been made aware of any issues around accessing patients by advocacy groups in the period since the last visit.

There were multiple sources of information for patients. There were notice boards in the wards that gave information on issues such as advocacy and services such as welfare advice. There was written information available as guides in the foyer which covered topics such as 'Rights, Duty of Candour', 'Confidentiality and Carers', and so on. They were available in easy read formats, which is important given that many patients may have communication issues and/or cognitive impairments. These guides

included an introduction to the service which had been written by a patient. However, we found that at least one of the guides – on rights and detention – did not have sufficient information on rights of appeal to the Mental Health Tribunal for Scotland (the Tribunal) and did not have appropriate information on making complaints (this was focussed on external agencies rather than their own internal complaints process).

Recommendation 1:

Managers should review all written information provided for patients, particularly with regards to information regarding their rights of appeal to the Tribunal and regarding the internal complaints procedure.

There was a monthly community group, which consulted patients on a wide range of issues. There was a family support group which was an important resource for carers.

Delayed discharges

Delayed discharges were identified as an issue in our last visit and formed one of our recommendations. The most recent information that we had indicates that there were currently five patients who were officially noted to have a delayed discharge. Whilst this was an improvement on our last visit this remains an area of concern and as such we believe that our previous recommendation should therefore remain in place for the time being.

Recommendation 2:

Managers should closely monitor and audit cases where patients are being delayed in moving from hospital to the community. The Commission should be informed when significant delays occur.

We are aware of plans for Graham Anderson House to expand, providing a community-based service to bridge existing local gaps in the Glasgow area. This remains a long-term plan but it is hoped that this will help with this issue.

Use of mental health and incapacity legislation

For the patients whose files we reviewed, all documentation relating to Adults with Incapacity (Scotland) Act 2000 (AWI) section 47 certificates were in place where necessary and were in date – we had checked this in particular in view of concerns raised about this at the last visit. We were pleased to be given information about monthly audits of this (and other documentation checks) in line with the recommendation in our last visit report.

Similarly all documentation regarding the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) was in place and easy to locate. For treatment under part 16 of the MHA, necessary consent to treatment certificates (T2) and certificates authorising treatment (T3) forms were in place and in date, and these were checked against prescription charts.

One of the patients we reviewed had been subject to the specified persons provisions of the MHA. The reasoned opinion relating to this was easy to find and carefully considered, with clear documentation of the strategies that had been used to try to avoid use of the legislation.

At least one of the patients that we spoke to was not aware of advance statements. We were unclear as to what steps are taken for the promotion of advance statements for patients in the facility.

Recommendation 3:

Managers should promote the use of advance statements. They may wish as part of this to consider undertaking a specific piece of work with the identified advocacy service for the facility to inform patients about their rights with a particular focus on advance statements.

Rights and restrictions

We considered patients' levels of restriction to leave the unit carefully in light of concerns raised in the last visit report. We found in the patients whose care we reviewed that there was clear link between their clinical progress and levels of risk and any restrictions placed on them.

For the patients we saw who were on enhanced levels of observation there was detailed descriptions of why this was necessary and for its use.

There was recording of capacity and consent relating to patient reviews, which was welcome in view of recommendations in our last visit report. We noted that the files recorded that staff would frequently check the patient's consent before interactions.

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/media/369925/human_rights_in_mental_health_services.pdf

Activity and occupation

Patients we spoke to told us about individual activity plans they had been given and which showed a wide range of activities. This had included encouragement of physical activity with sports opportunities such as a football group and inside the installation of a 'cardio wall'. There were opportunities for external activities including vocational activities.

The physical environment

The unit was welcoming in appearance and was clean throughout. The decoration in some of the common areas showed signs of becoming tired in appearance. The facilities run with relatively little storage space, as was evidenced by the furniture from one room having to be stored in a bathroom whilst it was being refurbished.

The patients' rooms were individual and en-suite. These were all personalised in a pleasing and appropriate way. Common areas were spacious, and there was a good range of spaces for various different activities appropriate to the different tasks of rehabilitation. There was good access to outside spaces, including to large internal courtyards for those patients who cannot leave the main building.

There has been effort put into enriching the environment and it was pleasing to see artwork produced by the patients displayed there and to see the external furniture which had been made by the patients in vocational groups.

Summary of recommendations

1. Managers should review all written information provided for patients, particularly with regards to information regarding their rights of appeal to the Tribunal and regarding the internal complaints procedure.

2. Managers should closely monitor and audit cases where patients are being delayed in moving from hospital to the community. The Commission should be informed when significant delays occur.

3. Managers should take steps to promote the use of advance statements. They may wish as part of this to consider undertaking a specific piece of work with the identified advocacy service for the facility to inform patients about their rights with a particular focus on advance statements.

Good practice

As noted above we especially wish to highlight that care plans and care planning was of a particularly high standard. Care plans were person centred and comprehensive. They had a good rehabilitation focus. Goals made good use of a SMART format. They made good use of graphical illustrations.

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.

Mike Diamond, Executive Director (Social Work)

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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