

Mental Welfare Commission for Scotland

Report on unannounced visit to:

Graham Anderson House, 1161 Springburn Road, Glasgow G21
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Date of visit: 23 January 2017

Where we visited

Graham Anderson House is a specialist independent service offering neuro-behavioural assessment and rehabilitation for individuals with non-progressive brain injury. The service is provided by the Brain Injury Rehabilitation Trust (BIRT), a charity which runs a network of specialist centres across the UK. Graham Anderson House is their only unit in Scotland.

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 newly built facility adjacent to the main hospital building. It opened in November 2015. 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 Graham Anderson House on 9 March 2016. We were impressed by the quality of care and treatment we found on this visit and made no recommendations for improvements at the time.

This unannounced visit followed issues being subsequently raised with the Commission from different agencies. The issues related to patient rights, restrictions and appropriate use of the Mental Health Act (MHA). We focussed our unannounced visit on these issues, reviewing the care of patients in the main hospital and on Heather Ward.

Who we met with

We met with and/or reviewed the care and treatment of 13 patients and one carer.

We spoke with the clinical director, the service manager, the head of care and a psychologist and charge nurse. In addition, we met with the Director of Clinical Services for the UK Brain Injury Rehabilitation Trust, who was visiting the unit that day. We also liaised with local advocacy services who provide input to the unit.

Commission visitors

Juliet Brock, Medical Officer

Paul Noyes, Social Work Officer

Jamie Aarons, Social Work Officer

Kathleen Taylor, Engagement and Participation Officer

What people told us and what we found

Care, treatment, support and participation

The patients we met with were mainly positive about their care and treatment. We found staff to be knowledgeable about the patients in their care and about their individual support needs.

The model of care at Graham Anderson House is one of psychosocial community rehabilitation. The service is psychology led, with input from a psychiatrist two days a week. Physical health care is provided by the local primary care service, with weekly GP visits offering 'open surgery' to patients in the hospital. Pharmacy input is also provided to audit prescribing. We found the care to be truly multidisciplinary, with a high level of psychology and occupational therapy (OT) input.

We found care plans to be person-centred and regularly reviewed. Multidisciplinary team (MDT) reviews were detailed and had a strong recovery focus, with an emphasis on individual goals and outcomes. The staff we met with spoke about an ethos of positive risk-taking and working progressively towards reduced levels of restriction for each patient in their care.

We saw evidence of effective community links supporting rehabilitation, with patients attending local gyms, participating in local projects such as wood-working and equine therapy and being involved in voluntary work with local charity shops and other organisations.

Physical health care

Patient case files showed evidence of routine physical health monitoring. We were advised that full, regular health screening is also carried out by the visiting GPs, supported by two ward staff. The central file containing details of this screening could unfortunately not be located on our visit as the members of staff were on leave. We would recommend that this information is kept in such a way that it is accessible on the ward at any time.

We were advised that the hospital are hoping to arrange input from a dietician to provide advice and support for patients, particularly around health promotion and healthy eating. We look forward to seeing this on future visits.

Participatory care

We heard from patients and staff about participation. We saw evidence of patient attendance and participation in MDT reviews and 'Care Plan Approach' meetings. There is a weekly patient forum group on the ward, facilitated by members of staff. Patient feedback is then provided at monthly hospital manager meetings. Patients spoke positively about this weekly forum and its outcomes.

Carers are encouraged to be involved in patient care and are invited to review meetings. The hospital also facilitates a monthly carer support group which families are encouraged to attend. This meeting is supported by psychology and also offers the opportunity for informal peer support.

We found the hospital to have a family-friendly approach. There is a family room offering private and comfortable visiting space with toys, games and books, as well as age appropriate information leaflets for children. There are flexible visiting hours. Family pets can also visit the unit, which staff told us that patients often find therapeutic.

Use of mental health and incapacity legislation

Many patients receiving care at Graham Anderson House have difficulties with aspects of cognition (such as concentration, memory or information processing). Where patients lack the capacity to consent to their care and treatment, or where their brain injury means that their ability to make decisions about treatment is significantly impaired, the Adults with Incapacity Act (AWI) and MHA can be used to safeguard their rights.

When we visited Graham Anderson House, of the 26 patients receiving care in the main wards and on Heather Ward, only seven were receiving treatment under the MHA. Five patients had guardianship in place and two patients had a power of attorney.

In a number of cases we reviewed, patients were receiving care and treatment on an informal basis but we considered whether their rights would have been better protected under the MHA. We raised these issues with senior members of staff on the day.

When discussing the MHA with staff, all were in agreement with providing care in line with the principles of the Act, but we found differing views on the use of this. While most considered that appropriate use of the Act was essential to protect patient rights, others were more reticent. One professional expressed concern that patients who

were subject to the Act were less likely to be accepted for supports or work placements in the community, thus affecting their rehabilitation and recovery. If this is the case, it represents unacceptable stigma and discrimination towards individuals on the basis of their mental health. Situations in which this is thought to have occurred should be brought to the attention of the Commission. Fear of stigma should not be a reason to avoid using the MHA where its use would be appropriate. It is there to protect the rights of the patient.

Recommendation 1:

Managers should ensure that at each multidisciplinary meeting, a patient's ability to consent to their care and treatment is reviewed. Use of the MHA or AWI Act must be considered whenever there are questions about an individual's capacity to consent to their care and any restrictions being placed upon them.

We were pleased to see in-house consent forms in case notes, indicating when a patient is consenting to being in hospital and to aspects of their care including restrictions being placed on them. However, in some instances a relative or carer had signed the form on behalf of the patient. We saw this done for an informal patient. If a patient is not able to provide valid consent themselves, again, legal safeguards should be considered.

Consent to Treatment

Mental Health Act

The patients who were receiving treatment under the MHA had valid consent to treatment certificates (T2) and certificates authorising treatment (T3) in place where appropriate.

Adults with Incapacity Act

Where patients do not have the capacity to consent to treatment for their physical or mental health, their doctor should issue a s47 certificate. This authorises medical treatment to be given in accordance with the AWI Act. Certificates should be renewed within a specified timescale. It is also good practice for an individual care plan to accompany this. On the day of our visit, one patient was being seen by their GP for the purpose of renewing their s47 certificate.

A central legal file is kept at the hospital containing copies of MHA and AWI Act documentation for all patients. Reviewing this file, we found that 15 of the 26 patients had a s47 certificate in place. Of concern, five of these certificates (one third) were out of date, with two certificates being over a year out of date. Not all certificates had individual care plans attached.

It is essential that consent to treatment documentation is kept up to date. Without this, staff are treating patients without legal authority being in place.

Recommendation 2:

Managers should ensure that all consent to treatment certificates are regularly reviewed and audited. Section 47 certificates should be accompanied by a care plan specific for the patient and documentation should be kept up to date.

Documentation

We were advised of a recent situation in which a patient transferring to Graham Anderson House was understood to have been receiving care and treatment under the MHA, but this was not in fact the case. This case raised issues which we are following up with the hospital in question. This situation also highlighted a failure in the pre-transfer assessment process. As this has not been a one-off event, we have made the following recommendation:

Recommendation 3:

Managers should ensure that when a patient is admitted to Graham Anderson House, copies of all MHA and/or any AWI Act documentation are obtained prior to transfer.

Rights and restrictions

There were some positive findings relating to patient rights and restrictions. Patients told us they were pleased to be allowed use of their mobile phones in hospital. There is also open access to the internet via computers on the main ward. Only one patient had been made a specified person and had some restrictions in place in this regard.

We did, however, have a number of wider concerns about patient rights and restrictions on this visit.

Patients on Heather Ward spoke positively about their freedom and lack of restriction, but contrasted this strongly with their previous experience in the main hospital.

The main hospital wards are kept locked and all patients require permission to have time outside. This is principally for reasons of safety. Time out on pass is dependent on a patient's individual care plans. A number of the patients we met in the main wards were unsure why some of these restrictions were being placed on them and they were unaware of their legal status or their rights.

We discussed individual cases with senior staff and raised question when we thought that patients may be having their liberty restricted or deprived without legal authorisation. This again raised the issues discussed in the previous section about legal safeguarding and appropriate use of the Act.

Recommendation 4:

Ward staff should ensure that each patient has been given verbal or written information about their legal status and their rights in a way they can understand.

Advocacy

Another concern we had was access to advocacy. Several patients we spoke with were unsure what advocacy was, or how they could access the service if they wished to.

Advocacy told us there were sometimes difficulties making arrangements to see patients on the ward. We were also informed, by both hospital and advocacy staff, about recent incidents which had led to some breakdown in communication between their services. We discussed these issues with senior managers on the day. We suggested that meetings are arranged with advocacy to address any current difficulties and to improve communication going forward. It is essential that patients have access to advocacy and it is important that the staff team in the hospital support this process.

Recommendation 5:

Managers should ensure that arrangements are in place so that patients have ready access to advocacy support.

Delayed discharges

We noted that many patients in the main two hospital wards were at different stages of the rehabilitation journey, whilst receiving care in the same environment, with the same environmental restrictions in place. For some, the environment seemed overly restrictive for their needs. For those patients who no longer required inpatient care, delays in moving to the community were a significant concern.

Several senior staff raised this issue with us. A number of patients were awaiting discharge to the community, but there had been significant delays in identifying appropriate placements or the required funding. Patients, carers and advocacy also highlighted these concerns to us. The Commission are looking into these individual cases with the local authorities concerned.

Recommendation 6:

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 heard from staff about different challenges in different local authority areas for patients when they leave hospital. The lack of specialist community support for individuals with brain injury is a problem. Eastfield was set up to provide an alternative

for individuals where specialist support was still needed, but we heard that funding is not always available from regional authorities.

We were told of future plans for Graham Anderson House to expand, providing a community based service to bridge existing local gaps in the Glasgow area. We will be interested to hear of further developments.

Activity and occupation

As mentioned previously, we saw evidence of a full and diverse programme of activity ranging from individual therapeutic work to therapeutic groups, physical, social and community activities, all with a focus on rehabilitation, recovery and enhancing skills.

The physical environment

Heather Ward is a bright, welcoming and spacious, purpose-built unit, designed specifically with the needs of the patient group in mind.

The main wards are in the original hospital, where administrative offices and wards interconnect in a single storey building. The environment is clean and is currently being refurbished, with new carpets being installed in ward areas and patient rooms. Bedrooms are all single rooms with en-suite facilities. There were also accessible bedroom and bathroom facilities to accommodate wheelchair bound patients.

The wards have access to enclosed garden spaces, one of which has an outdoor gym. Inside there is an OT kitchen where patients can prepare meals, laundry facilities, a newly decorated and homely TV lounge with a well-stocked library, and an IT hub where patients have access to computers. There is a large dining room and other areas for group activities.

We noted that patient names were on doors and that pictures were used to help patients navigate different spaces in the wards.

Summary of recommendations

1. Managers should ensure that at each multidisciplinary meeting, a patient's ability to consent to their care and treatment is reviewed. Use of the MHA or AWI Act must be considered whenever there are questions about an individual's capacity to consent to their care and any restrictions being placed upon them.
2. Managers should ensure that all consent to treatment certificates are regularly reviewed and audited. Section 47 certificates should be accompanied by a care plan specific for the patient.

3. Managers should ensure that when a patient is admitted to Graham Anderson House, copies of any MHA and/or any AWI Act documentation are obtained prior to transfer.
4. Ward staff should ensure that each patient has been given information about their legal status and rights in a way they can understand.
5. Managers should ensure that arrangements are in place so that patients have ready access to advocacy support.
6. Managers should closely monitor and audit cases when patients are being delayed in moving from hospital to the community. The Commission should be informed when significant delays occur.

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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