Mental Welfare Commission for Scotland

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

Date of visit: 22 January 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Graham Anderson House is an independent, specialist mixed-sex rehabilitation service for people with a non-progressive acquired brain injury, owned by Brainkind and regulated by Healthcare Improvement Scotland. People are initially admitted for a 12-week programme which comprises four weeks of assessment followed by eight weeks of rehabilitation, after which further rehabilitation will be agreed on, on an individual basis, depending on each person's specific needs.

The service is made up of different units. Watten Ward is a 20-bedded, acute neuro-rehabilitation ward that also has a self-contained, one bedroomed flat. Earn Ward is a five-bedded unit for people with more intensive support needs. Heather Ward is in an adjacent building and is a four-bedded unit for people who are more independent, or who may benefit from a quieter environment. Eastfields Unit is also on the site of Graham Anderson House. It is a separate community care service which is regulated by the Care Inspectorate. We did not visit this service.

On the day of our visit, there were 27 people in the service. During our visit we heard that eight people were 'delayed discharges' meaning that they were ready to be discharged but that an appropriate package of support had not yet been identified for them. We will continue to review the care and treatment of these individuals to ensure that everything is in place to support their leaving hospital.

We last visited Graham Anderson House in February 2023 on an announced visit and made a recommendation regarding the need for meaningful review of care plans, of including the individual in these reviews and ensuring that they can access their care plans. We were told by senior staff that the care plan system had been updated to an electronic version at the time of the last visit. We were told that at that time when staff were reviewing and updating people's care plans that previous versions and updates were no longer visible. We were advised that this issue had been resolved.

On the day of this visit, we wanted to follow up on the previous recommendation. We had been told about recent issues with medication which we were keen to review. We had also heard about problems with communication between health and social care teams and families that we wanted to explore.

Who we met with

We met with and reviewed the care of 14 people, nine of whom we met with in person, and we reviewed eight sets of care records. We also met with/spoke with seven relatives.

We spoke with the service manager, the ward manager, the Mental Health Act administrator and consultant psychiatrist.

Commission visitors

Sheena Jones, consultant psychiatrist

Gemma Maguire, social work officer

Kirsty MacLeod, engagement and participation officer

What people told us and what we found

Many of the people that we spoke to said that Graham Anderson House was the best unit that they had been in and that the staff were “great”. People spoke about not being able to get the care they needed in the services they were in before they came to Graham Anderson House.

People told us that they valued the support that they had from their psychologist and their occupational therapist, one person said they “didn’t know where they would be” without their occupational therapist.

The majority of people that we spoke to said that most of the support workers in the service were “brilliant and caring”. Some people spoke about having some staff that they liked and some that they did not.

Two people told us that they don’t always get their medication at mealtimes when they expected to. They might have to wait which they found frustrating. We spoke to the service manager about this at the time of our visit. They were unaware that this had been an issue and intended to follow this up. We have since heard from the service that the nursing team regularly monitor people’s blood sugar levels and will administer medication as set out in their care plans. This may sometimes mean that medication is given later than the person may expect but is in line with practice guidelines.

One person told us that the communication was poor between the staff. They gave the example that their doctor had said that they could have 30 minutes to go out with the service, but they were only allowed 15 minutes by the nursing team, which they found difficult.

One person told us they “didn’t like it here” and it “felt like a sentence”. They said that they felt like they were in “solitary confinement” and spoke about wanting to go back to their own home. The same person told us that they had not been home in over two years, however, we could see in their records that they had had recent visits to their home with their occupational therapist and support workers.

Another person also spoke about feeling like the service was a prison. They spoke about not understanding what their diagnosis was and why they were in the service. They said that they had not seen their care plans. Their family member agreed with them that they didn’t know what their activities were, what their care plans indicated and didn’t understand what their discharge plan might be.

One person spoke about the support that they had in the service and how this had helped them to come to accept their brain injury and to stop being angry about it.

We heard from another person who told us about how much they valued taking part in the thinking skills group and showed us some of the resources that they had from that group.

One relative said that Graham Anderson House was a “wonderful place”. Their relative had been in a wheelchair on arrival and “within a month he was walking”. They said that the staff were “so good with him”.

One relative told us about the family support meetings. They thought that they were good and informative, although the information that was covered was quite general. The relative told us that they had understood that there would be further smaller group meetings to consider each individuals needs in more detail. We heard from the service that they do have a counsellor who meets with family members individually.

Another family member told us that the service was the busiest that they had ever seen it. They said that people were often just in their rooms and that you could never find anyone to speak to you.

We heard mixed views about the food in the service. One person told us that there was a good range of vegan food available whilst another said that the options were very limited. We heard from the service manager that the service user committee had also raised this issue, and some work had been done to increase the variety available. A suggestion form for alternative foods had also been provided in one of the serveries.

When we visited, we saw that the staff were engaging in a positive and caring way with the people in the service. We were also provided with all the help that we needed.

Care, treatment, support, and participation

Care records

We reviewed care records in paper and electronic format at the time of our visit. We reviewed the paper medication charts and a range of legal documentation held in paper format in folders.

Care plans were held on ‘My Plan’, the electronic system for the service, while multidisciplinary team (MDT) and meeting information was held separately in shared electronic drives.

We could see a wide range of information relating to each individual’s specific care and treatment needs in My Plan with various care plans that had clear outcomes, time scales and reviews that were linked with the weekly MDT meetings. Care plans covered a broad range of rehabilitation needs, including physical health.

When we asked people about their care plans, they generally did not know what we meant. People did not have copies of their care plans, and we did not see alternative versions of these that might be more meaningful or accessible to individuals with communication or memory issues resulting from their brain injuries. We spoke to senior staff about this, and they advised that there were difficulties in providing people with paper copies of their care plans due to issues in relation to data protection and confidentiality. We have seen paper and easy read versions of care plans successfully introduced in other services with people being able to keep these in their rooms if they so wish.

It was clear from the care plans we reviewed, and from the MDT meeting minutes, that people were involved in the development of their care plans and their feedback was regularly sought, however, this did not lead to people having a clear understanding of their care plans and how these might link with their activities and their rehabilitation goals.

One family told us that their relative's medication was changed without their agreement, even though they were the person's welfare guardians. However, we heard from senior staff that they had fully consulted with the person's welfare guardians prior to medication being changed and heard that the person had improved following this and was now working towards discharge.

The Commission has published a good practice guide on care plans[1]. 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.

We had made a recommendation at our last visit with regards to people having access to their care plans and this recommendation has been repeated.

Recommendation 1:
Managers should ensure that people can access their care plans and reviews as they wish. Where appropriate, care plans should be provided in the accessible format which is most meaningful to each person and may include the use of easy read or visual information. It may be helpful for people to be provided with copies of their accessible care plans, should they wish them.

Multidisciplinary team (MDT)

The MDT at Graham Anderson House is well resourced and includes nursing, occupational therapy (OT), physiotherapy, psychiatry, psychology and speech and language therapy.

We heard that there had been a recent recruitment process and that the service was fully established with regards to the nursing team. In general, three nurses worked

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[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

day shift, and two nurses worked at night. Whilst agency staff had been in place previously, this was now only required in exceptional circumstances.

We heard the OT team linked with community services as part of each person's rehabilitation process.

With regards to medical staff, there was one consultant psychiatrist who worked part-time and a locum specialty doctor who worked 21 hours per week. There were two consultant psychologists in the service, one full-time and one part-time. There was a full-time clinical psychologist vacancy.

There was a service level agreement with a local GP surgery who provided twice weekly visits to the service. This also meant that the service could access other primary care services including dietetics, phlebotomy (blood testing), skin integrity and diabetic nurse.

There were therapy assistants in the service who supported the work of OT, psychology and speech therapy staff, which included a full-time therapy assistant, a part-time assistant, and a part-time vocational co-ordinator.

There was a weekly MDT meeting, which was led by the ward manager and attended by most members of the MDT. People who were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) were discussed at this meeting. It was evident that the numbers of people in the service who were subject to the Mental Health Act had significantly increased in recent years. The MDT also included a walk around the service and gave the opportunity for people and their families to meet with the consultant psychiatrist.

At the end of each meeting the ward manager and the consultant psychiatrist agreed the minute of the meeting, including an agreed action plan, which was then shared with the service staff on the shared electronic drive.

The service shared information with us regarding how often people were reviewed at the MDT meetings. This varied with how long the person had been in the service, their stage of recovery and in relation to specific legal requirements. Some people are reviewed every two weeks, some, every month and some, every two to three months.

While the service had been described as psychology-led, we heard that people who were subject to the Mental Health Act considered that it was their consultant psychiatrist who was the lead professional in their care and treatment. We heard from people that they were advised that they may have to wait to speak to their psychiatrist for decisions to be made. An example of this was in relation to people's time out from the service. One person said that they had not seen their psychiatrist for three weeks and felt that the doctor had 'too many patients'.

The service manager reiterated this and told us that the feedback received from the service user group was that they did not see their psychiatrist enough. In response to this a locum staff grade psychiatrist had recently been appointed and a permanent post was being advertised. We look forward to hearing how this supports people to meet with the medical team in relation to decisions about their care and treatment.

We reviewed the electronic records from the multidisciplinary meetings and found them to be extremely detailed. They covered a wide range of relevant information including a range of actions and goals to be achieved in a specified time frame, physical health monitoring, review of medication and medication changes, a current risk assessment, status of care plans and when they need to be reviewed and information in relation to the mental health and capacity legislation.

The involvement of each person in their own MDT meeting was evident in the recordings, with feedback included from both the individual and their family members. The person's ability to engage in therapeutic activities was also recorded and there was additional information about their behavioural state and any specific monitoring of the person's aggression, where relevant.

People who were not subject to the Mental Health Act were reviewed through psychology-led meetings; we also reviewed the minutes of these meetings. These records were as detailed as the MDT minutes and contained a wide range of relevant information. We could see that people's engagement in activities was regularly recorded and what the therapeutic intention was for those activities.

We saw regular involvement from advocacy in people's care records and heard from individuals how they valued this. Some people were not clear about the role of advocacy and did not think that they had seen an advocate, but we could see in their notes that they had been referred to advocacy and were in contact with their advocate and also solicitors, if they wished. At the time of our visit we suggested that some individuals may benefit from accessible information about their care and treatment given their memory impairment and this links with the recommendation about care plans made above.

One person told us that the intention was for them be moved to a different region of Scotland that they had no connection with, and which would be a distance from the few local contacts that they had. We spoke to the service about this on the day and it would appear that there was not a confirmed plan at that time.

Medical errors
We had been told before our visit about two medication errors that had occurred since our last visit.

We spoke with one individual who had been given the incorrect dose of medication over a long period of time. They said that this was a real problem for them and asked if we knew what had happened. We were able to tell the person that we had seen the action plan that the service had created after the error was identified. The action plan contained a range of requirements for the service, including the requirement that two staff members check medication sheets, and that there was regular audit and training. The person told us that they would also like to see this information and we asked the service manager to share this with them at the time of our visit. We heard from senior staff that the person had been fully informed about everything that had been done. We recognise that the information may need to be shared on a number of occasions due to the person's brain injury and the impact that this has on their memory.

We reviewed the paper medication charts in each unit when we were reviewing certificates for to consent to treatment. The medication charts list all prescribed medication with the dose, formulation and frequency of prescription and information about when medication was given. We found that the paper charts were stored in ring binders and that there were holes punched in the charts to allow them to be stored in the folders. In one case this meant that it was not possible to read the dose of a person's medication and in another case the name of the medication was missing.

We spoke to the service manager on the day to urgently address this issue to ensure that there were no further medication errors. We were assured that the incomplete charts would be replaced that day and that new folders had been ordered to prevent this from happening again.

Recommendation 2:
The service manager and lead nurse should ensure that medication charts are properly stored to prevent information about medication from being incomplete and incorporate a regular review of prescribing sheets into the ongoing medication audit.

We reviewed audit and action plans in relation to the recent significant medication error and although these were detailed and comprehensive, we continued to have concerns about safe medication prescribing. We have contacted Healthcare Improvement Scotland to highlight these concerns, given their involvement in the recent medication audit process.

The service manager told us that they were in the process of identifying an electronic medication system to replace the current paper prescribing processes. An electronic system could also mean that there would be pharmacy input to the service which would be beneficial in providing additional oversight of prescribing and administration of medication given the recent issues.

Recommendation 3:
The service manager should review the need for an electronic prescribing system and involvement of a pharmacist in the service as a priority to ensure the correct prescribing and administration of medication.

Use of mental health and incapacity legislation

On the day of the visit, 17 people were detained under the Mental Health Act.

All documentation relating to the Mental Health Act, including certificates around capacity to consent to treatment were easily found. This information was stored in the medication folders in each unit along with other relevant information such as Adults with Incapacity (Scotland) Act, 2000 (AWI Act) forms and treatment plans, medication prescribing protocols and information relating to physical health.

A family member told us that their relative was subject to the Mental Health Act and that this had been put in place after their relative had not wanted to return to the unit after a visit home. We heard that the person had agreed to return with support from family but that the police then attended and returned them to the service. The family member we spoke said that they did not think that this had helped their relative. They told us that it was far harder now to make plans for them, that some requests to leave hospital for family events were refused and that none of this would have been necessary if things had been handled better. We also heard that the person's phone could be removed if they are upset and that this felt like a punishment and was reflective of a very restrictive approach to their relative's care and treatment. We have given advice to this person and their family about their legal options.

We have since heard from senior staff that at the time this individual required detention under the Mental Health Act, that their family and carers were fully involved in the decision-making process and their return to the service. Senior staff also provided assurances that this person's phone had not been removed.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and in all but one case, corresponded to the medication being prescribed.

In one of the units that we visited, the team leader we spoke to did not know what a T3 form was, although this was then found in the medication folder. In one case there was a medication missing from a T2 form and we spoke to staff to ensure that this was followed up on the day.

We also reviewed records in relation to the use of the AWI Act.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. There was a section 47 certificate in place for most people in the service.

Nine people had either a welfare attorney or welfare guardian in place and for a further nine people, an application was in progress for a welfare guardianship (this included applications made by the local authority and applications being made by families).

At the time of our visit, we reviewed information in relation to AWI Act in a specific folder where such information was kept. Whilst the majority of the information in relation to the AWI Act was available in the paper records, there were some documents that we could not find on the day and had to locate after our visit. One person was subject to welfare guardianship but the staff we spoke to were unclear what powers were in place. Another person had information about the application process under the AWI Act, but this did not include the document that detailed the specific powers that were in place. We discussed this with the staff team at the time of our visit.

We intend to visit the service again in the coming months to meet with people who are subject to welfare guardianship to look at their care and treatment in more detail.

The Commission has worked jointly with NHS Education for Scotland (NES) to develop training in relation to the AWI Act and an eLearning module has recently been launched on TURAS. This can be accessed by anyone in the workforce and has been developed for those working with people aged 16+ years who may be considered to lack capacity to make some or all decisions.

Recommendation 4:
The service manager should ensure Mental Health Act and AWI Act training is delivered to all relevant staff to ensure that they understand the legal basis by which they can provide physical and medical treatment to people who are considered to lack capacity to consent to treatment.

Rights and restrictions

We heard from some of the people that we spoke to, and saw in their care records, that people were regularly meeting with their advocates who were supporting them with regards to their legal rights, including the appeals process.

We heard that a number of people were subject to enhanced levels of observation and continuous interventions by one of more members of staff. This included support for people who were at risk of falling, people who needed support to eat safely, people who were vulnerable and had been hurt by others and individuals who posed a risk to others due to their behaviour.

We met two people who were being supported by two members of staff at all times. We were told that this was in place due to the risk to the person and others due to unpredictable destructive and aggressive behaviour. We could see that for periods of time the support workers would be sitting out with the person’s room; at the time of our visit while we saw friendly interactions between the person and the staff, and heard about how they supported them with personal care and activities, we were concerned about the level of restriction the person faced and the impact that this could have had on them.

One family we spoke to told us that their relative had three members of staff with them at all times. They did not know if there was a specific incident that had led to this being put in place and did not feel that they had a clear understanding of what actions the staff might take if their relative became distressed. They also told us that their family member can ask for activities. They didn’t know what activities staff would do with their relative and thought that the staff would “struggle” to know what to do. Senior staff have since advised us that three to one care had been required for an individual after a significant assault on another. We heard that family were informed of this, and that the local authority was also notified via adult support and protection processes.

We were also told by a family that their relative’s mobile phone could be removed from them at times of distress and the family thought that this felt like punishment and also prevented them from contacting family when they were distressed. We sought more information about this from the service manager. We were told that this person’s phone had not been removed. We also heard that when there are any restrictions in place for people with regards to the use of their phones that the person would be made a specified person under the Mental Health Act.

Sections 281 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 person is specified in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied.

Where specified person restrictions were in place under the Mental Health Act, we found that the appropriate forms (RES 1) had been completed to notify the Commission that individuals were subject to this legislation. We saw documentation in relation to people having restrictions placed on their access to telephones, their use of the internet and with regards to correspondence and safety and security in hospital.

We found no reasoned opinions in the care records that we reviewed, as is required, and no evidence that the person had been informed in writing. The forms that record which specific restrictions were in place with regards to telephone usage (RES 3) and correspondence (RES 6) had not been completed.

Recommendation 5:
Managers should review all documentation for people who are specified under the Mental Health Act and ensure that there are reasoned opinions and necessary documentation with regards to the specific restrictions in place in line with the Commissions good practice guidance on specified persons. They should also ensure that people are aware of their rights to appeal their status as a specified person.

Recommendation 6:
Managers should ensure MDT training in the application and use of specified persons to enhance all staff's understanding of specified person legislation.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they do or do not want. Health boards have a responsibility for promoting advance statements. The majority of people in the service were considered to lack capacity, therefore we did not see any advance statements.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

On the day of our visit, we saw people going out with staff for walks, to the local shop and heard about a range of activities that people took part in. We also saw some people taking part in a group news session in one of the lounges.

One person told us that they had their own timetable of activities as they didn't enjoy all the activities on offer. They told us that they had had few outings in the time that they were in the service and that the weekends were boring.

Another person told us there was nothing to do and spoke about being bored. They said that they had been out recently but that was "only because the Commission was coming to visit". We could see in the person's MDT care plans that new activities were being sought and that this was expected to be achieved in the near future. We

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[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

could also see that the MDT met regularly with the person and a record was kept of the therapeutic activities that were happening.

One person said that they did not like the in-house activities; they were not of interest to the person. They preferred to go out but would often have to wait until there was someone available to go out with them. This person said that they had not been out for weeks before our visit, but it was evident in their care plan that they had been out every day in the preceding week and had attended some activities during that time.

Another person told us that the in-house activities were good and that in addition to the knitting and shopping activities they also intended to join an exercise group as this was something that they had enjoyed in the past.

We saw the timetable for the week displayed on the wall in the corridor and were provided with timetables for the month, which was helpful. The timetables were completed on a spreadsheet and information about activities was written in small print. There was a wide range of activities and detail in the timetables that would be valuable to the staff team, but we did not find the timetables easy to read. We heard that the noticeboard in the main corridor was primarily for staff and that easy read and picture timetables were available for people should they wish.

When we reviewed people's care records, we saw information recorded about people's preferred activities using an interest check list.

In the minutes of the MDT meetings, we also saw information about how often people took part in the activities that were available to them.

There were a number of resources available to people in the service and these included indoor and outdoor gym spaces, a computer area for people who did not have their own access to this, cardio wall equipment, a pool table, televisions and books. One person told us that there was "no point in having outdoor space as the doors are always locked". We heard from senior staff that the doors to outdoor spaces would be locked at times, such as when group sessions were occurring, to encourage people to participate in those activities.

We heard that here was a regular café in one of the courtyards that appeared to have a social function. One person told us how much they enjoyed their regular yoga sessions in the service. We also heard about woodwork sessions. Other activities included walking groups, a steps challenge, walking football, in-house quizzes and visits from a music student.

We heard from one person that they had had the opportunity to present the previous day at a lecture for psychology students at Glasgow University and what this had meant to them and how it had helped their confidence.

The service manager advised us that the Mental Health Tribunal for Scotland had made recorded matters in relation to people being able to access activities and spoke about the range of activities that were on offer. We heard that some people's motivation levels could be affected by their brain injury.

It was evident from the information that we reviewed during our visit that a range of therapeutic activities were on offer for people in the service. It was also clear that sometimes people struggled to engage in activities due to their motivation levels and at times it was not clear to people what the therapeutic intention of their activities was. Whilst there was some information in people's rooms about the different professionals involved in their care, we did not see any individualised timetables or activity plans in an accessible format that might make this more meaningful for people. We also heard that people were keen to have more leisure activities and that this was particularly important at weekends.

We heard that the service had recently appointed an activity co-ordinator. We did not meet with them on the day of our visit. We look forward to meeting them on future visits and hearing about the progress that they have made.

Recommendation 7:
The service manager, in conjunction with the multidisciplinary team should review the need for people to have their own accessible weekly activity plans that link with their care plans and specific therapeutic goals.

The physical environment

Graham Anderson House was accessed via a large reception area. There were pictures of all the staff members in reception and we saw staff put up posters about local advocacy services when we arrived.

Earn Ward was accessed through double doors on the right of the reception area and Watten was accessed to the left. We walked through Earn Ward into Watten Ward and also visited the one-bedroom flat that was in one corner of Watten Ward. The corridors were bright and clean and tidy. It was evident that some signage and pictures had been damaged, and temporary signage was in place. We heard that new pictures and signs were in the process of being put up.

All of the bedrooms in the service were en-suite. People had personalised their rooms with their own belongings. This included musical equipment, laptops, pictures and posters.

There were a number of dining and lounge areas in the service that gave people different options for where to have their meals and how many people they shared the space with. We saw that many of the rooms were multi-purpose with dining tables, sports and gym equipment and television and music equipment.

During our visit we observed new furniture throughout the ward with new sofas and chairs replacing those which families told us had been ripped and broken.

In the servery area we saw the menu for the day and vegetarian options were also available.

We visited the therapy kitchen in Watten Ward and saw a well-equipped wheelchair-accessible space, with an adjustable height hob.

Each unit that we visited had its own office space and treatment room. Care records (paper and electronic) were kept in the offices and medication charts, drug trolleys and equipment were kept in the treatment rooms.

In the service there were a number of internal courtyard areas allowing people to go outside. These had gym equipment and garden furniture to allow people to sit outside in good weather. We saw that there were new keypads in place which would allow people to be able to go outside without the need to ask staff to unlock the doors. The people we spoke to told us that they did not yet have the codes to allow them to freely access these courtyard spaces and we look forward to hearing about the progress of this.

The single bedroom flat had a bedroom, bathroom and lounge area. From the lounge area there was access to a patio. In the lounge we could see new furniture, a television, a table for meals and a small kitchen area with a microwave and a toaster.

Heather Unit was a smaller four-person unit in an adjacent building. We heard from people that this was a quieter unit which people liked. They also liked the larger rooms. Each room was en-suite and had a small, fenced garden area accessible through a patio door. There was a small kitchen where people could prepare their own meals, a dining area and a lounge with books, a television and a pool table. We also saw a laundry area that was shared by everyone in the unit.

At the time of our previous visit the service was noted to be too hot. In comparison when we visited this time, many areas of the service were cold and this made certain rooms, such as the gym, unwelcoming. We heard that people had to wear their coats inside to keep warm. We also heard this from family members. We could see that small heaters were in use in some areas to keep people warm.

Recommendation 8:
The service manager should review the heating in the service to ensure that people are comfortable.

Any other comments

One person we met with did not speak English. They spoke to us about their isolation, the lack of contact with their own community and the difficulty they had in communicating with other people in the service. They told us that they did not like the food and that did not know if they could be supported to cook their own preferred food. We spoke to the service manager at the time of the visit. It is important that this, and any person in a similar situation, is supported to ensure that their communication and cultural needs are met.

Summary of recommendations

Recommendation 1:

Managers should ensure that people can access their care plans and reviews as they wish. Where appropriate, care plans should be provided in the accessible format which is most meaningful to each person and may include the use of easy read or visual information. It may be helpful for people to be provided with copies of their accessible care plans, should they wish them.

Recommendation 2:

The service manager and lead nurse should ensure that medication charts are properly stored to prevent information about medication from being incomplete and incorporate a regular review of prescribing sheets into the ongoing medication audit.

Recommendation 3:

The service manager should review the need for an electronic prescribing system and involvement of a pharmacist in the service as a priority to ensure the correct prescribing and administration of medication.

Recommendation 4:

The service manager should ensure Mental Health Act and AWI Act training is delivered to all relevant staff to ensure that they understand the legal basis by which they can provide physical and medical treatment to people who are considered to lack capacity to consent to treatment.

Recommendation 5:

Managers should review all documentation for people who are specified under the Mental Health Act and ensure that there are reasoned opinions and necessary documentation with regards to the specific restrictions in place in line with the Commissions good practice guidance on specified persons. They should also ensure that people are aware of their rights to appeal their status as a specified person.

Recommendation 6:

Managers should ensure MDT training in the application and use of specified persons to enhance all staff's understanding of specified person legislation.

Recommendation 7:

The service manager, in conjunction with the multi-disciplinary team should review the need for people to have their own accessible weekly activity plans that link with their care plans and specific therapeutic goals.

Recommendation 8:

The service manager should review the heating in the service to ensure that people are comfortable.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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 an individual's care, treatment, and support are 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