Mental Welfare Commission for Scotland

Report on announced visit to: Surehaven, 3 Drumchapel Place, Glasgow, G15 6BN

Date of visit: 26 November 2020

Where we visited

Due to the Covid-19 pandemic, the Commission postponed all scheduled local visits in March 2020. From August 2020 the Commission undertook a phased return to our visit programme following recommendations in the Scottish Government's roadmap to recovery.

We were keen to visit Surehaven as it had been some time since our last local visit and we had received some correspondence regarding the ward from patients. Additionally, as a low secure forensic unit, patients at Surehaven may potentially be subject to additional levels of restrictions. On the day of this visit we wanted to follow up on the previous recommendations and also find out how the service had managed throughout the current Covid-19 pandemic, specifically in relation to the impact of restrictions, contact with relatives, reductions in opportunities for rehabilitative activities out with the hospital and on the mental health of patients. We wanted to to give patients an opportunity to raise any issues with us and to ensure the care and treatment and the facilities are meeting patients' needs.

This local visit was undertaken using a combination of telephone interviews, video interviews and in person interviews on site at Surehaven.

Surehaven is a low secure, independent, psychiatric hospital located in Glasgow. The hospital has 21 inpatient beds accommodated in two wards. Campsie Ward accommodates six female patients, and Kelvin Ward accommodates 15 male patients. On the day of our visit the hospital was at the full occupancy of 21 patients.

We last visited this service on 18 October 2018 and made recommendations regarding care and treatment plans, and mental health legislation.

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We also looked at:

- Care, treatment, support and participation
- Use of mental health act and incapacity legislation
- Rights and restrictions
- Therapeutic activity and occupation
- The physical environment

Who we met with

We met with and/or reviewed the care and treatment of nine patients and spoke with four sets of relatives. We spoke with hospital manager, the clinical nurse specialist, senior and junior nursing staff, occupational therapy (OT) staff and the Healthcare Inspectorate Scotland Officer.

Commission visitors

Lesley Paterson, Nursing Officer

Anne Buchanan, Nursing Officer

What people told us and what we found

We heard that patient care has continued very much as normal throughout the Covid-19 pandemic with patients continuing to have good access to their clinical team and advocacy services. We were pleased to hear that although subject to some ongoing restrictions, most patients have generally coped very well with the experience of the ongoing pandemic and understand the need for the restrictions and change in practices.

Care, treatment, support and participation

We heard from senior management that there continues to be significant demand for places. The unit almost always operates at full capacity and there is a long waiting list for new admissions. There were a number of patients who had been in this hospital for several years. This was largely due to the complexity of their needs and the challenge in finding services to support their needs within their home health board. A large cohort of the patient population is from the Lothian area, where there is currently no local low secure provision. We were told there are currently more females referred than males, which is problematic due to the bed configuration.

Some of the patient group had no forensic history and had been admitted to Surehaven to manage behaviours which had proven to be challenging within their own health board. We were told the average length of patient stay is 18 – 24 months however a number of patients had been there for much longer.

This can impact on their ability to maintain contact with their families and friends and was reflected in the conversations we had with some patients.

Most of the patients we met spoke positively about aspects of their care and treatment and favorably of their contact with nursing, occupational therapy and psychology staff. All of the relatives and carers whom we spoke to were remarkably positive about the standard of care and treatment delivered and commented that staff were engaging, approachable and some went ‘above and beyond’ what was expected of them. They felt involved in their relatives care and treatment and felt recovery was promoted.

Our last report recommended that care plans should address the specific needs of individual patients and be reviewed to reflect any changes in care needs. We were pleased to see that the standard of the nursing and OT care plans is much improved. We found care plans to be detailed, person-centred, and it was evident from the information contained within the patient record that staff know their patients very well.

All patients are managed on the Enhanced Care programming Approach (CPA) and we found CPA documentation to be of a high standard and demonstrated that patient and relative input was encouraged.

Multidisciplinary (MDT) meetings for each ward take place once per week, on the same day. We heard from staff that although this may suit some members of the clinical team, others

find this difficult to manage.

Recommendation 1:

Managers should review the current arrangement for MDT meetings.

It was clear to see who attended each MDT meeting and outcomes / actions were clearly documented. Patients are invited to attend the MDT meeting however if they choose not to, nursing staff will liaise with them prior to the meeting to ensure their views are conveyed and then provide post meeting feedback afterwards. When appropriate, relatives are invited to attend MDT meetings via video conferencing. There was evidence of robust and regular risk assessment utilising a variety of validated risk assessment tools. It was clear from talking to patients and reviewing their notes that they are very involved in their care and treatment.

Some patients told us that they don't see their consultant psychiatrist as often as they would like. We noted that there appears to be a standard whereby each patient be reviewed by their psychiatrist a minimum of once per month. Although in fact patients may be seen more often, we asked managers to consider if they felt this was an acceptable level of minimum medical review for patients in a low secure unit subject to restrictions on their liberty.

Recommendation 2:

Managers should review the minimum timescales for medical reviews.

It was clear from the health records, and from speaking with patients. that there is a great deal of involvement from psychology, occupational therapy, pharmacy, speech and language therapy, and physiotherapy when required. The psychologist works three days per week and there were some really comprehensive and useful psychological assessments, formulations and treatment plans contained within the records. We were told that the psychologist also provides regular reflective practice sessions and one-to-one wellbeing sessions for staff, if required.

There was evidence that physical healthcare monitoring was a priority. Referrals are made to physiotherapy, dietetics, podiatry or speech and language therapy if required and patients are supported to attend all national screening initiatives as necessary. There is a visiting GP service and we saw evidence of annual health checks along with any other required monitoring including bloods for Clozapine therapy, high dose antipsychotic monitoring, and diabetic monitoring.

A significant issue for patients and families across Scotland has been maintaining contact during the Covid-19 pandemic due to national restrictions on hospital visiting. Surehaven staff have prioritised family contact and patients have been able to maintain telephone or video call contact where appropriate. Patients and relatives spoke favourably of the staff efforts to encourage and maintain contact with carers and families throughout the pandemic. Surehaven has an established carer's programme which is predominantly lead by occupational therapy staff.

We were pleased to see regular contact from Surehaven to the patient's home health board in that a monthly summary is compiled and sent to them. We could, however, see little

evidence of communication from the home health board and, although invited, they did not appear to routinely attend CPA meetings or reviews. This two way communication is important in relation to ongoing care, treatment and discharge planning and ensuring that patients do not get 'forgotten about'.

There is a very useful checklist in each patient's file to prompt monthly discussion between the named nurse and the patient on advanced statements, advocacy, named person, and consent to information sharing. A number of patients we spoke with were very aware of advocacy services and had advocacy workers who supported them and attended CPA meetings if requested. Staff and patients spoke positively regarding the advocacy provision.

Use of mental health and incapacity legislation

At the time of our visit thirteen patients were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') on compulsory treatment orders and eight were detained under the Criminal Procedure (Scotland) Act 1995 on compulsion orders with restriction orders. This is what we would expect due to the restrictions placed on them in a low secure locked environment.

Patients we interviewed were clear about their legal status. Most of the patients had spent many years in hospital and were aware of their rights in relation to their detention and had legal representatives.

Part 16 (S235-248) of the Mental Health Act sets out the conditions under which treatment may be given to those patients who are subject to compulsory measures, who are either capable or incapable of consenting to specific treatments. We had concerns regarding the practices around the consent to treatment certificates (T2) and certificate authorising treatment (T3) forms where required. It was evident that some psychotropic medication had been omitted from the T2 and / or the T3 form and in one case it appeared a T2 form may have been completed due to a second opinion medical assessment not being requested in order to obtain a T3. In other instances medication was being prescribed and administered without the legal authority to do so as the T3 had expired and the patient had not consented to treatment via a T2.

Lastly, we saw examples of as required medication, including intra-muscular injections being administered for agitation on a T2. Our view is that a patient is very unlikely to be consenting to IM medication for agitation at the time this is felt to be urgently necessary and would recommend this is authorised under a T3.

Recommendation 3:

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

Rights and restrictions

Patients at Surehaven are in a locked environment for reasons of patient safety and risk factors. Many of the patients, however, had agreed plans allowing for short spells of suspension of their detention to allow for periods of escorted or unescorted time out of the ward to aid their recovery and rehabilitation.

Patients generally had good access to phones and technology, which is not always the case for patients in low secure facilities. There were appropriate risk assessments in place to support this policy. Patients also generally had free access to their rooms throughout the day.

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/rights-in-mind/

Sections 281-286 of the Mental Health Act provide a framework within which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed. This is necessary to provide legislative authority for this restriction. It also provides the appropriate framework for review of the restrictions and the patient with their right to appeal against these.

On our last visit we recommended that managers reviewed practice in relation to the use of specified persons. On this occasion there was only one patient who was subject to specified person status, however although the relevant paperwork was in place, staff seemed to be unsure about what this meant in practice. Additionally there were a few patients who were subject to urine drug screens and room searches who were not specified. Although we were told by staff that patients consented to these procedures, it was clear from the patient records that although consent was given for urine drug screens, there was at least one patient who had previously tested positive for illicit drugs and had been told that their time out with the ward would not be reinstated until they provided a negative urine sample. We believe this is not truly consensual as there may be an element of coercion.

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

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

Recommendation 4:

Managers should ensure specified persons procedures are implemented for patients where this is required to legally authorise room searches, urine drug screens or other restrictions.

Activity and occupation

Most patients in the ward are involved in a good range of activities including cooking groups, walking groups, art and crafts, gardening, socialisation through games, themed nights and life skills groups. Attendance at community resources such as The Common Wheel, The Coach House, Flourish House to name a few are currently suspended due to the Covid-19 pandemic, however staff have been creative in considering alternative activities. Some patients were difficult to motivate in activity, but we noted considerable efforts to develop activities in relation to their interests.

Given the length of time many patients have spent on the ward, they have developed good relationships with staff, and have been able to pursue and cultivate their interests over time. Some patients have been able to develop interests into volunteering opportunities and engagement in local community groups.

Unlike many other low security facilities, most patients had access to their own phones and internet (subject to individual risk assessments), and patients appreciated the ability to use these in relation to communication and entertainment.

The physical environment

The ward environments were pleasant with patients having their own individual en-suite room which they were able to personalise with their own belongings. There was much attention to detail and staff had assisted patients with personalising their bedrooms. The wards felt calm and had a quiet atmosphere. There was evidence of purposeful activities being carried out. The garden space was adequate and there were no environmental issues raised with us by patients or staff during our visit.

Any other comments

Other issues raised by staff in relation to individual patient care and treatment will be addressed directly with the Responsible Medical Officer (RMO).

Summary of recommendations

1. Managers should review the current arrangement for MDT meetings.

2. Managers should review the minimum timescales for medical reviews.

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

4. Managers should ensure specified persons procedures are implemented for patients where this is required to legally authorise room searches, urine drug screens or other restrictions.

Good practice

We noted the efforts of the clinical nurse specialist to ensure a wide variety of training to enhance the care and treatment they provide. We feel this is positive and not only focuses on each staff member's strengths and areas of interest but fosters a sense of ownership, and allows staff to develop specialist knowledge which can be promoted and shared within the team.
Although the Covid-19 situation has been a devastating and traumatic time, it has presented challenges that have required collaboration, commitment and creativity to find new ways of working. We were impressed with the way in which this service has adapted and it is hoped the positive changes that have benefitted some aspects of patient care can be continued and developed in future models of care.

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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