**Mental Welfare Commission for Scotland**

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

**Date of visit:** 28 August 2021

## 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 route map to recovery. There have been periods during the pandemic where we have been unable to conduct our face to face visits, however this local visit was able to be carried out face-to-face.

Our visit was unannounced, meaning the service was given no prior warning or notification of it. On the day of this visit we wanted to follow up on the previous recommendations and also find out how the service had continued to manage 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.

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 26 November 2020 and made four recommendations regarding multidisciplinary team meetings, medical reviews and mental health legislation.

## Who we met with

As our visit was, on this occasion, unannounced, patients, relatives and staff had no prior warning or notification of our arrival, and so did not have the opportunity to plan for contact with, or arrange appointments with us. We did however meet with and/or reviewed the care and treatment of five patients. We spoke with the clinical nurse Specialist, the consultant psychiatrist, senior and junior nursing staff on the day of the visit and the hospital manager the following week.

## 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 continued to cope very well with the experience of the ongoing pandemic and have understood 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 admission. 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 the 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 number of the patients are 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 inpatient services. 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 members of the clinical team. We were pleased to see that the standard of the nursing and occupational therapy (OT) care plans continues to be high. 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.

On our last visit we found that multidisciplinary (MDT) meetings for each ward were taking place once per week, on the same day, and that some staff found this difficult to manage. We made a recommendation that managers review this arrangement and were pleased to hear that the MDT meetings now take place separately over two days and staff report this is more manageable and less stressful. They also note that the quality of the meetings have improved and more time is taken to discuss each patient.

It is clear to see who attended each MDT meeting and outcomes/actions are 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.

Following our last visit we made a recommendation that the minimum timescale for medical review be reconsidered as the standard at that time was a minimum of monthly review and some patients told us that they didn't feel they saw their consultant psychiatrist as often as they would like. We were pleased to hear that patients are being reviewed more frequently now and the patients we spoke with commented favorably on the increase in frequency of contact they have with their psychiatrist.

It was clear from the health records and from speaking with patients that there continues to be is a great deal of involvement from psychology, OT, pharmacy, speech and language therapy, and physiotherapy when required. We noted there were some comprehensive and useful psychological assessments, formulations and treatment plans contained within the records and 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 remains 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 and lithium 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 continued to prioritise family contact and patients have been able to maintain telephone or video call contact where appropriate and have moved to face-to -face visiting as restrictions have allowed. Patients 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 OT staff. 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.

The 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 of the advocacy provision.

On our last visit to the service we were pleased to see regular contact from Surehaven to the patient's home health board with a monthly summary which 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. We commented that this two way communication is important in relation to ongoing care, treatment and discharge planning and ensuring that patients do not get 'forgotten about'. On exploring this area on this visit, whilst we could see more medical input involved with the monthly summaries, there continued to be little engagement from the home Health Board.

**Recommendation 1:**
Managers should implement a system to ensure and evidence clear liaison and two way communication between Surehaven and the patients home Health Board.

## Use of mental health and incapacity legislation

At the time of our visit, fifteen patients were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 ) ('the Mental Health Act') on compulsory treatment orders and six 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. On our last visit to the service we raised concern regarding the practices around the consent to treatment certificates (T2) and certificate authorising treatment (T3) forms. While there has been improvement in this area, it was evident that there are still some outstanding issues. Additionally, Surehaven have in place a system for telephone prescribing if a prescription is required out-with the hours that a medic is on site. In these instances a telephone discussion would take place between the nurse and the medic which would be followed up with an email confirming the prescription and then the prescription kardex would be updated and signed by the Doctor at the next MDT meeting. While there is a protocol for this, we had concerns about the requirement and robustness of this process and noted that the prescription kardex was not always updated and signed at a later date, which we felt was unacceptable. We also felt that some of the medications which were prescribed could have been done so within working hours if discussions between the clinical team had taken place at that time.

**Recommendation 2:**

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.

**Recommendation 3:**

Managers should review the Telephone Prescription Protocol and audit its use to ensure it is fully adhered to and used only in emergency situations.

## 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/law-and-rights/rights-mind

Section 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 and that this legislation is implemented for patients where this is required to legally authorise room searches, urine drug screens or other restrictions. We were pleased to see that specified person legislation was now being implemented appropriately.

Our specified persons good practice guidance is available on our website at:

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

## 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 had been suspended due to the Covid-19 pandemic.

However, as we emerge from the pandemic, these resources are due to open. Staff continue to be creative in considering alternative activities and we noted continued considerable efforts to develop activities in relation to their each patient's individual 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.

As mentioned above, 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

Following our last visit we raised some other issues which had been brought to our attention by staff in relation to individual patient care and treatment, with senior managers and the responsible medical officer (RMO). We were pleased to hear that concerns in these areas have lessened, certain aspects of care and treatment have improved and governance systems have been put in place to enhance the quality of patient care delivery, increase accountability and improve the working environment at Surehaven.

## Summary of recommendations

1. Managers should implement a system to ensure and evidence clear liaison and two way communication between Surehaven and the patients home Health Board.

2. 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.

3. Managers should review the Telephone Prescription Protocol and audit its use to ensure it is fully adhered to and used only in emergency situations.

## Good practice

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.

SUZANNE MCGUINNESS
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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