Mental Welfare Commission for Scotland

Report on announced visit to:

Surehaven Hospital, 3 Drumchapel Place, Glasgow, G15 6BN

Date of visit: 25 October 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Surehaven is a low secure, independent, psychiatric hospital located in Glasgow. The hospital has 21 in-patient beds across two wards. Campsie Ward accommodates six female patients, and Kelvin Ward accommodates 15 male patients. On the day of our visit the hospital was almost at capacity. The unit has a multidisciplinary team (MDT) consisting of nursing staff, psychiatrists, occupational therapy (OT), psychology staff and an activity co-ordinator. Referrals can be made to all other services as and when required.

We last visited this service on 26 November, 2020 and made recommendations regarding multidisciplinary team meetings, recording of specified persons information, the timing of medical reviews and authority to treat documentation.

The response we received from the service was that all of the recommendations had been addressed and audits were in place to ensure ongoing standards were being met appropriately.

On the day of this visit we wanted to follow up on the previous recommendations and also to hear how patients and staff have manged throughout the covid 19 pandemic.

Who we met with

We met with, and reviewed the care of eight patients, seven who we met with in person and one who we reviewed the care notes of. We also met with with two relatives.

We spoke with the service manager, the senior charge nurse, the clinical nurse specialist, one of the consultant psychiatrists and occupational therapy staff, as well as nursing staff and the psychologist.

Commission visitors

Margo Fyfe, senior manager (practitioners) west team

Kathleen Taylor, engagement & participation officer (carers)

Justin McNicholl, social work officer

What people told us and what we found

As at the time of our last visit we were informed that on the whole, patients had coped well during the pandemic. We heard about the positive family contact during lockdowns and of the staff's sensitivity to family and patient needs and the efforts made to ensure patients met with families. We heard that different ways of maintaining contact with families was put in place during lockdowns, including Skype and Zoom. When visits went ahead, they were in line with the Scottish government advice, and adapted as restrictions eased. It was good to hear that any information letters for families and patients regarding government advice were regularly shared.

We were told that staffing has remained at a good level throughout the pandemic. Surehaven have their own staff bank and do not need to use agency staff. During pandemic restrictions, psychology and complementary therapy continued to provide staff and patient support. There is also a counselling psychologist available for staff, if required.

Care, treatment, support and participation

As at the time of our last visit, managers confirmed that there continues to be significant demand for places. Although there was a vacant bed on the day of our visit we were informed that an admission was expected. We were told that NHS Lothian purchase eight beds and are always able to ensure that these are occupied as there is no low secure service in Edinburgh. Patients are often in the unit for several years and the average stay is between two to three years. This is largely due to the complexity of the patients needs and the challenge in finding services that offer this level of support in the patient's home health board area.

Throughout the visit we saw kind and caring interactions between staff and patients. Staff whom we spoke with knew the patient group well and the patients whom we met with praised the staff highly.

The patients we met with were positive about their care and treatment; they told us of the support they received from staff and were happy with the activities on offer to help them in their recovery journey. The relatives we met with were also very positive about all care and treatment and told us of the consultant psychiatrist going above and beyond by contacting family members to provide updates. We heard that the psychiatrist was also willing to provide any general information and answer worries and concerns that the relatives had, without being asked to do so. We were told that the consultant psychiatrist and psychologist will often invite families at the time of admission, to share background information that then helps to enrich the care offered. It was good to hear that families are invited to Christmas afternoon tea and the summer fete if patients agree to this.

All patients have a named nurse in place with regular one-to-one sessions consistently offered. Patients told us they felt listened to and part of the decision making around their treatment. They are invited to attend regular multidisciplinary team (MDT) review meetings and if they decline to attend on two occasions, the consultant psychiatrist and named nurse will meet with the patient on the ward to review them on a one-to-one basis to ensure that the patient's views are heard and taken to the MDT meeting. This was an area we had made a recommendation around when we last visited. We saw good evidence of this practice happening in care notes. We saw clearly documented review information from all disciplines

involved in each patient's care and treatment that was gathered monthly and informed the MDT reviews. It was good to see that the patients have access to the wider team as required and that there is an emphasise on psychological interventions alongside the medical interventions on offer. Psychology assessments and treatment plans were easily accessible in the care folders. We also heard that the psychologist has continued to provide regular reflective practice sessions and one-to-one wellbeing sessions for staff, if required.

There is a visiting GP service and we saw evidence of annual health checks along with other physical health monitoring. We were told that referrals out with the service for physical health care, including dentistry, are prioritised.

We found examples of detailed and person-centred care plans that addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the individual. We saw evidence of patient involvement and when speaking with patients they were aware of their care plans and knew they could have a copy of these if they wished. It was good to see that care plans were being regularly reviewed however, we would have liked to see more information detailed regarding changes to care plans in light of the review, identifying what interventions in the care plan were not working.

We also found comprehensive recordings in patients' one-to-one discussions with their named nurse.

The Commission has published a good practice guide on care plans. 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, and can be found at:
https://www.mwcscot.org.uk/node/1203

Recommendation 1:
Managers should audit care plan reviews to ensure issues identified in reviews are reflected appropriately in changes to care plans and that reviews detail any future plans to be progressed by the next review.

All patients are managed on the enhanced care programming approach (CPA) and as at the time of our last visit, we found CPA documentation to be of a high standard that demonstrated patient and relative input was encouraged.

Use of mental health and incapacity legislation

At the time of our visit all patients patients were subject detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') on compulsory treatment orders or detained under the Criminal Procedure (Scotland) Act 1995 on compulsion orders with restriction orders; this is appropriate due to the restrictions placed on individuals requiring care and treatment in a low secure environment. We were able to easily locate legal documentation relating to detention orders in the care files.

However, when looking at the guardianship status of patients under the Adults with Incapacity (Scotland) Act 2000 (AWI), we found the interlocutor for one patient, where there was a financial guardian in place, was not on file. Following discussion with managers, they assured

us they would contact the solicitor concerned to ensure they had a copy for the care file. This is required as it details the powers in place around the individual's financial management.

Patients we interviewed had an understanding of 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 in place.

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. During our last visit we had concerns regarding the practices required with consent to treatment certificates (T2) and certificates authorising treatment (T3) forms, where applicable. We found that some psychotropic medication had been omitted from the T2 and/or the T3 forms. On this occasion we found two forms where there were issues regarding medication being given out with the authority of the T3 forms held on file; however, when we discussed this with the consultant psychiatrist, we were advised that arrangements were being progressed to rectify these issues.

For some patients who lacked capacity to consent to medical treatment, their care was authorised by a section 47 certificate under AWI. Although we found all section 47 certificates in place, we could not locate any treatment plans that should accompany the certificates. We discussed this with the consultant psychiatrist and how they benefit the understanding of all in regard to what the section 47 certificate covers. We were informed that this issue would be addressed as soon as possible.

In October 2021, the Mental Welfare Commission published an advice note entitled *The scope and limitations of the use of section 47 of the Adults with Incapacity Act*. This is a practice guide that sets out a more accurate terminology that aimss to avoid confusion. This can be found at: https://www.mwcscot.org.uk/node/1638

Rights and restrictions

Both wards in Surehaven continue to operate a locked door, commensurate with the level of risk identified in the patient group. As at the time of our last visit, we found some of the patients had agreed plans allowing for brief periods where there was a suspension of their detention; this was to allow for periods of escorted or unescorted time out of the ward, to aid their recovery and rehabilitation. The time out was clearly planned and recorded.

When we are reviewing patient files we looked for copies of advance statements. The term 'advance statement' refers to written statements made under s274 and s276 of the Mental Health Act, and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. Where these were done by patients we found copies in files. We also found evidence of regular reminders to patients that these can be done and it was recorded where patients were clear in their views noting they did not wish to have an advance statement.

It was good to see that patients had access to their rooms throughout the day, as well as access to laptops and telephones.

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

We saw evidence of regular review when patients were being nursed on enhanced observations. Nurses who were involved in this intervention ensured that the patients needs continued to be met.

Sections 281-286 of the Mental Health Act provides a framework in 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 any identified restriction. It also provides the appropriate framework for review of the restrictions and the patient's 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 we were pleased to see the relevant forms (RES1) were in place where a person was specified. However, we could not find any reasoned opinions attached to the RES1 forms. We explained that we would expect to see a record of the reasoned opinion in the patient's notes. We suggested that staff adopt the practice of another low secure unit, who attach a copy of the letter they give to the patient, informing them of their specified status, and add this to the patient's file.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/418

Recommendation 2:
Consultant psychiatrists should ensure that reasoned opinions for specified persons are available alongside the RES1 forms in each individual's care file.

Activity and occupation

Patients in the ward are involved in a good range of activities. We were very pleased to see these included cooking groups, walking groups, art and crafts, gardening, socialisation through games, themed nights and life skills groups. There is also access to an art therapist and complementary therapy; these therapists visit the ward and provides sessions to both patients and staff to enhance general wellbeing. We heard that attendance at community groups was being reinstated as Covid-19 restrictions have lifted. We noted the efforts of OT and nursing staff to develop activity plans that meet the individual's needs.

We heard of two patients currently studying open university courses and being supported by staff in their studies.

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 in volunteering opportunities and engagement in local community groups.

One area of importance in regard to activity that we were informed about during our previous visit was that most patients had access to their own phones and internet (subject to individual risk assessments). Patients told us they appreciated the ability to use these in relation to communication and entertainment.

The physical environment

The wards are in a purpose-built environment. They are bright and clean and have space for patients to have their own areas, with bedrooms that are personalised. There are areas that provide a quiet space as well as a communal space in the unit; these are in addition to the well-kept and pleasant garden.

Summary of recommendations

Recommendation 1:
Managers should audit care plan reviews to ensure issues identified in reviews are reflected appropriately in changes to care plans and that reviews detail any future plans to be progressed by the next review.

Recommendation 2:
Consultant psychiatrists should ensure that reasoned opinions for specified persons are available alongside the RES1 forms in each individual's care file.

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.

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 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.

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