Mental Welfare Commission for Scotland

Report on announced visit to:

Surehaven, 3 Drumchapel Place, Glasgow, G15 6BN

Date of visit: 15 January 2024

Where we visited

Surehaven is a low-secure, independent, psychiatric hospital located in Drumchapel, on the outskirts of Glasgow. The hospital is managed by the Shaw Healthcare group, and Surehaven is their only Scottish-based hospital; the company headquarters are in Cardiff. The hospital has 21 inpatient beds across two wards. Campsie Ward accommodates six female patients, and Kelvin Ward accommodates 15 male patients. The layout of the hospital, and facilities are unchanged since our previous visit in October 2022. On the day of our visit there were no vacant beds.

Low-secure forensic wards generally have a higher ratio of staff to patients and a locked door. It would be expected that staff working in this setting have particular skills and experience in caring for acutely ill and often distressed patients.

We last visited this service in October 2022, and made recommendations regarding the need to ensure that care plan reviews were audited and that reasoned opinions for any individuals who are subject to specified person restrictions were recorded. The response we received from the service was that all of the recommendations had been addressed and audits were in place to ensure standards were being met appropriately.

On the day of the visit, we wanted to give patients an opportunity to speak with us regarding their care and treatment. We wanted to ensure that care and treatment was being provided in line with mental health legislation and in a human rights compliant model.

Who we met with

Prior to the visit, we held a virtual meeting with the managers of the hospital to discuss any changes to the service since our last visit.

On the day of the visit we met with, and reviewed the care of seven patients, four of whom we met with in person and three of whom we reviewed their care notes. We also met with two relatives.

We spoke with the general manager, the ward manager, the clinical nurse specialist, and two of the occupational therapy staff as well as various nursing staff.

Commission visitors

Justin McNicholl, social work officer

Mary Leroy, nursing officer

Susan Hynes, nursing officer

What people told us and what we found

Care, treatment, support and participation

During our meetings with individuals, we discussed a range of topics that included contact with staff, participation in their care and treatment, activities that were available to them and their views of the environment. We were also keen to hear from those who had been in Surehaven for a number of years and those who were preparing for discharge.

The majority of people that we spoke with were satisfied with the nursing and allied health professionals' (AHPs) care and support. Individuals spoke positively of staff; "they look after me very well" and I'm very happy with the care they give me". We heard how individuals were regularly supported to maintain contact with their family members, both on the ward and in their local communities. One stated, "they regularly take me to see my mum which is very important to me" and another commented, "I meet my family in Glasgow and this really helps."

We heard very positive feedback from relatives about the care delivered. This included, "they have saved his life, previously he could not go out alone and now he has unescorted leave. I cannot thank them enough". One relative praised the support on offer to carers, "the occupational therapist has linked me in with my local carers group." We heard from one relative who was disappointed that their views as a named person had not being taken into consideration prior when a specific treatment was given. The relative advised us that they had taken this forward through the complaints process and since received a satisfactory response.

Most patients and relatives expressed the view that named persons were regularly able access to the care team and could ask open questions about future care planning from the lead consultant psychiatrist for the hospital. It was clear from observations and individual reports that patients generally trusted the staff and found the environment a safe place to stay.

All the staff members we spoke with knew the patients well and were able to comment on any risks, restrictions and management plans. The care we observed throughout the day of the visit appeared to be personalised and focused on both group and individual recovery goals. We noted that the majority of the female patients in Campsie Ward had been in the hospital for several years due to their illness; despite this, it was evident that staff were continuing to seek ways to promote independence and provide care in a person-centred manner. We found evidence that on occasions, when patients were not keen to participate in group activities, these would be attempted on a one-to-one basis with greater success. This persistence by the care staff, in wanting to aid individuals in their recovery, appeared to deliver many positive outcomes for the patients across both wards.

We heard from management that recruitment and retention of nursing staff was not currently a challenge as staff tended to remain in their posts in the hospital. We heard from staff that they felt "valued" and "listened to by managers and that any evidence of poor practice was swiftly addressed". Managers advised us that the staff in the service tended to pick up additional shifts when needed, and that this ensured that safe staffing levels were met. It was

positive to note that currently, there are no agency staff utilised by the hospital which has helped to provide consistent care for the patient group.

We heard from some individuals that they had regular access to activities in the hospital, and with local community groups. We were able to observe patients accessing college courses online, use the onsite gym and other activities via the occupational therapy staff.

During this visit we heard from staff that psychology staff were supplying regular input to the hospital. We were not able to meet with the psychology staff during the visit however we hope to do this during out next visit. Psychological support is essential in a forensic setting due to the complexities that many of the patients face. The hospital employs an independent forensic psychologist who completes the Historical, Clinical and Risk Management-20 **(**HCR-20) reports. Staff advised of the positive impact that psychology staff have, which includes assisting in developing and reviewing behavioural strategies for the patient group and providing one-to-one supervision sessions for staff.

We are aware over the last year of some of the significant challenges that patients and staff have faced in Surehaven with ensuring access to mental health officers (MHOs) from Glasgow Health and Social Care Partnership (HSCP). It was positive to hear during our visit that all patients currently had access to an MHO, as and when required. Social work input was noted to be in place for the most of the significant meetings. We did note that there continues to be challenges with Glasgow HSCP ensuring timely discharges from Surehaven for some individuals. As Surehaven is an independent hospital, it does not hold an official delayed discharge list that links in with the monitoring provision of this, held by NHS Greater Glasgow and Clyde (NHSGGC). The result of this is that at least two patients have been waiting considerable periods of time to be discharged to the community, with no clear timescales as to when their community placements will be made available. This may result in patients having to seek judicial reviews into their circumstances due to the excessive delay in being moved to conditions of lesser security in the community. We will continue to monitor these cases and seek to ensure that Glasgow HSCP is addressing these matters.

Care records

Information on patients' care and treatment was held in paper files. We found these to be well-organised, easy to navigate and allowed all professionals the ability to record their clinical contact in the relevant sections of each patient's file. We heard from managers that there is a plan to move to an electronic recording system in the future and we look forward to seeing how this is implemented during future visits.

All patients across the hospital were subject to the Care Programme Approach (CPA). This approach was coordinated by staff onsite and ensured that meetings for patients care took place regularly and were recorded to a consistent standard. There was evidence of patients, relatives and advocacy staff participating in these meetings, as well as MHOs and social workers. Risk assessment and management documentation was also found in the care records.

Our last report recommended that care plans should be regularly reviewed to address the specific needs of individual patients and to reflect any changes. We were pleased to see that

the standard of the care plan reviews was much improved. We found care plans to be detailed, person-centred and addressed the individuals' needs alongside their goals.

Multi-disciplinary team (MDT)

We were pleased to note that both wards had a full multi-disciplinary team (MDT) including psychiatry, nursing, occupational therapy, psychology and other professions as and when required. The recording of the MDT meetings were found to be consistent, with evidence of engagement and participation by patients, relatives and their named persons. It was positive to note that practice had been adjusted since our last visit, to ensure that those patients who did not attend MDT meetings were seen regularly by the psychiatrist to discuss, and review their care. It was reported that this takes place before the MDT to ensure that any views expressed are considered and if required, actioned at the meeting.

We saw that physical health care needs were being addressed and followed up appropriately, and relevant physical health monitoring was in place. The point of access for individuals requiring urgent health care was via the local health centre. The management praised the local general practitioners who were noted to be responsive, ensuring that patients were referred to the appropriate secondary care services as and when required.

Use of mental health and incapacity legislation

On the day of our visit, all 21 of the patients in Surehaven were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') or the Criminal Procedure (Scotland) Act 1995 (CPSA) as we would expect in a low-secure setting. The majority of the orders in place were under the Mental Health Act. The appropriate detention paperwork was readily available.

All documentation relating to the Mental Health Act, the CPSA and Adults with Incapacity (Scotland) Act 2000 (the AWI Act), including certificates around capacity to consent to treatment, were in place in the paper files and were up-to-date. Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, 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 corresponded to the medication being prescribed.

Where a power of attorney (POA) or guardianship order under the AWI Act is in place, a copy of the powers granted should be held in the patient's care file and the proxy decision maker should be consulted appropriately. We found where there was a proxy, this was recorded, and copies of the powers were available in the care files we reviewed.

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. We found section 47 certificates in place for all patients that we reviewed and where a proxy decision maker was appointed, they had been consulted. When an individual is subject to section 47, we would expect to see a treatment plan on an Annex 5 form. This is completed by the clinician with overall responsibility for the patient. The

treatment plan should be written to include all of the healthcare interventions that are anticipated during the time specified in the certificate. The treatment plan should be clear on whether the patient has capacity to make decisions regarding their healthcare needs. We found no treatment plans attached to the section 47 certificates that we reviewed.

Recommendation 1:
Medical staff should ensure that, where a section 47 certificate is in place that an accompanying treatment plan is also completed.

Rights and restrictions

Patients at Surehaven are in a locked, secure environment for reasons of safety and for the management of identified risk factors. The restrictions that were in place were understood by those that we spoke with. Many of the patients had agreed plans allowing for the suspension of their detention, 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.

The majority of the patients we spoke to had a good knowledge of their legal status and rights; they also had advocacy support or knew how to access this service, as well as legal representation. Managers highlighted the ease of access to advocacy services from the local provider.

When we are reviewing patients' files we looked for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 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. We found clear evidence of advance statements on file for patients and regular reviews revisiting their wishes in relation to these. We found evidence of when patients had opted not to complete an advance statement, and this was revisited on a monthly basis along with named person nomination forms.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are subject to detention 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 to be regularly reviewed. There were 11 patients on the day of our visit who were subject to restrictions. We were told that these arrangements are reviewed regularly to determine whether restrictions were still required. On our last visit we recommended that relevant forms (RES1) should have reasoned opinions attached. We explained to managers that we would expect to see a record of the reasoned opinion in the care notes.

We were pleased to see that our recommendation had been adopted in line with other low-secure units, who attach a copy of the letter they give to each patient, informing them of their specified status, and that this had been add this to the patient's record. We were able to find RES3 and RES6 forms.

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

https://www.mwcscot.org.uk/node/418

At the time of this visit there were no patients on enhanced observations in either ward. The hospital does not use seclusion to manage distress experienced by any patients, and individuals could access their rooms freely throughout the day.

For several years, Surehaven has used closed-circuit TV (CCTV) across all the communal areas of the ward. There are no cameras in the patients' bedrooms, toilets, showers or bathrooms. Prior to our visit to Surehaven, we were alerted to the fact that in the last two years, the Shaw healthcare group have adopted new policies, procedures and access arrangements surrounding the use of CCTV. Initially, the new arrangements introduced reduced managers access to footage across the hospital site. We were informed that steps are being taken to re-introduce access to the CCTV footage for Surehaven staff, and were advised that this is for footage to be used as a clinical tool to manage patient risks and investigate incidents in the hospital.

The Commission has developed the *Rights, risks and limits to freedom* good practice guide which can be found on our website, and *Decisions about technology* - *Safe to wander* good practice guide.

We have advised Surehaven to ensure that any use of CCTV complies with a human rights based approach. We requested that managers keep the Commission informed of any progress or change in practice which impacts upon the rights of the individuals in their care.

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

Activity and occupation

Since our last visit, we were pleased to note that patients appear to have had increased access to a range of recreational and therapeutic activities both in the hospital and in the local community. Attendance at community resources such as The Common Wheel and Flourish House continues to provide motivation for patients to engage in meaningful activity, however access to these services is restricted to only NHSGGC patients. For those patients who cannot access these services, due to them being residents from out with the Greater Glasgow and Clyde area, there are a range of alternative activities. These include access to tennis, walking, football, and climbing groups. In the ward, there are structured activities which focus on personal care.

There is input from the local minister and church groups, who visit the hospital regularly. Managers informed us of plans to have planned input from a local music project which they hope will provide benefit to the patient group.

Unlike many other low secure 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.

We found clear evidence of input from the occupational therapy staff. This was recorded in the care record and was to a high standard; records demonstrated the steps that had been taken to engage and motivate patients to undertake activities.

The physical environment

The wards are based across two separate floors in the hospital. When entering through the reception area, there is information on display for visitors. There is a multidisciplinary room with a CCTV camera in place on the first floor of the building. We were advised that this camera was due to be removed in the coming weeks. We visited the treatment room and bathroom in Kelvin Ward as we were informed of plans to convert the bathroom into a new treatment room to provide adequate space to undertake physical examinations of patients; this is currently not possible due the size of the treatment room. We were advised that a smaller bathroom will be reinstated in the location of the current treatment room, which aims to minimise any disruption to patients.

The male ward is considerably larger than the female ward. There are three separate garden areas which appeared safe and provided privacy to the patients. One of the garden areas is for patients to meet with relatives and is utilised on a regular basis. There are communal benches in place to allow patients to sit and relax. We were told that the garden area is popular with patients and visitors alike.

Patients continue to have access to their own individual en-suite bedroom which they are encouraged to personalise with their own belongings. During our visit, the ward atmosphere was calm and quiet.

We heard from managers of plans over the next two years to extend the hospital, creating a further 12 beds for patients, and office space for hospital staff. These new beds will be built on the site of the current large garden at the rear of the hospital. This extension will create increased low secure capacity for forensic patients. Part of this redesign will include adjustments to the layout of the current hospital. We were advised that various plans have been put in place to minimise disruption to the current patient group. We look forward to visiting the hospital in the future to review the impact these adjustments will make to patient care and treatment.

We found a number of repairs during our visit that need addressing, this includes significant stains to the various walls throughout the wards and non-patient spaces. Several chairs, the carpets and walls appeared tired and required updating. We found unpleasant sewage smells coming from the toilets in the building which will need addressing as a priority.

Recommendation 2:
Managers should ensure a programme of work, with identified timescales, is put in place to address the environmental issues.

Summary of recommendations

Recommendation 1:
Medical staff should ensure that, where a section 47 certificate is in place that an accompanying treatment plan is required, it is completed for all patients.

Recommendation 2:
Managers should ensure a programme of work, with identified timescales, is put in place to address the environmental issues.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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.

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