

Mental Welfare Commission for Scotland

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

Date of visit: 18 October 2018

Where we visited

Surehaven is a low secure, independent, psychiatric hospital. The hospital has 21 inpatient beds accommodated in two wards. Campsie Ward accommodates six female patients. Kelvin Ward and an annex accommodate 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 3 May 2017 and made a number of recommendations relating to recording of information, patient participation in care, access to advocacy and psychology, and authorisation of medication.

Our main reason for visiting on this occasion was as part of our regular visits to adult forensic wards where patients are subject to restrictions on their liberty. We wanted to follow up on our previous recommendations and to look at general issues important for patient care.

Who we met with

We met with and/or reviewed the care and treatment of nine patients across the two wards. None of the patients' carers, relatives or friends asked to meet or speak with us with regard to our visit.

In addition, we met with the hospital manager, psychiatrist, and senior nurses to discuss current issues and developments.

Commission visitors

Paul Noyes, Social Work Officer

Mary Hattie, Nursing Officer

Moira Healy, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

We heard from managers that there continued to be considerable demand for places. The unit is currently full and there is a waiting list for new admissions. Surehaven has a considerable number of patients from the Lothian area, where there is currently no local low security provision, and there has recently been additional demand from other areas due to pressures on their low security beds.

The majority of patients at Surehaven were patients on 'civil orders', not orders from the criminal courts; many are longer term patients that had been challenging to manage in wards in their own health board areas. Most of the patients we spoke to

had in fact been at Surehaven for several years, and for some this created difficulties in maintaining contact and links with family in their home areas.

Patients on all the wards were very positive about their care and treatment and generally spoke favourably about their relationships with nursing and medical staff. The wards had a calm and quiet atmosphere with lots of purposeful activity taking place.

Our last report made recommendations relating to the need for improvement of recording of patient information. We noted on this visit that this had improved and we noted good care plans, reviews, and risk assessments in patient files.

We did however raise an issue that, for patients who have been in the unit for several years, it is important to revisit initial care plans and risk assessments to reflect their current situation.

Recommendation 1:

Managers should ensure that care plans address the specific needs of individual patients and are reviewed to reflect any changes in care needs.

It was clear from talking to patients, and from looking at their notes, that they are involved in their care and this involvement is now more clearly documented in multi-disciplinary team (MDT) records. It was also evident that patients are having regular meetings with their psychiatrist.

As well as good medical and nursing input, we also noted good multidisciplinary involvement from psychology, occupational therapy, pharmacy, speech and language therapy, and physiotherapy when required.

The need for improvement to psychology services for patients at Surehaven was highlighted in our last report. On this visit we noted improved psychology input, with many patients receiving regular psychology input, with clear goals and information for nursing staff to improve support.

We noted efforts to encourage and maintain contact with carers and families, with many patients receiving escorted visits to their home areas. We were also pleased to see good evidence of contact with mental health officers (MHOs) and clinicians from patients' home areas, which is important in relation to ongoing care planning.

We were assured patients had access to advocacy and are encouraged to make use of advocacy services, particularly at review meetings. We noted that a number of patients we spoke with had advocacy workers and were aware of advocacy services; no one from advocacy was, however, present during our visit.

Use of mental health and incapacity legislation

All patients in Surehaven at the time of our visit were detained patients. This is as we would expect due to the restrictions placed on them in a low secure locked environment.

For the patients whose notes we reviewed, we found the appropriate detention paperwork. Patients we interviewed were clear about their status, as were the staff. 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.

We also established that patients had consent to treatment certificates (T2) and certificate authorising treatment (T3) forms where required. We also found appropriate monitoring for patients on high dose medication.

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 in their recovery.

Patients generally had good access to phones and technology, which is not always the case for patients in low security conditions. Appropriate risk assessments support this policy. Patients also generally had free access to their rooms throughout the day.

A small number of patients were subject to specified person restrictions, mainly relating to the use of telephones. Documentation in relation to the use of specified persons, however, requires to be improved as we could not find the required reasoned opinions in patient records. Patients also require to be made aware of the review and appeal processes.

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/>

Recommendation 2:

Managers require to review practice in relation to the use of specified persons in relation to Commission guidance.

Activity and occupation

Most patients we reviewed were involved in a good range of activities both on the ward and also in the community. Some patients were difficult to motivate in activity, but we noted considerable efforts to develop activities in relation to their interests. Occupational therapists ran a number of on-site groups including cookery, arts and

crafts, gardening, and life skills. A number of patients spoke of walking and exercise activities which they enjoy, and a range of visits and outings. Staff also arranged social activities and events.

Given the length of time many patients have spent on the ward, they had been able to develop good relationships with staff, and pursue their interests over time. Some patients had 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 utilise these benefits in relation to communication and entertainment.

The physical environment

The physical environment improvements highlighted in our last visit appeared to have been maintained. The ward environments were pleasant with patients having their own individual rooms which they were able to personalise with their own belongings.

No environmental issues were raised with us by patients or staff during the visit. We did, however, note improvements to the garden area on Kelvin Ward and an interesting eco-greenhouse which was under construction.

Summary of recommendations

1. Managers should ensure that care plans address the specific needs of individual patients and are reviewed to reflect any changes in care needs.
2. Managers require to review practice in relation to the use of specified persons in relation to Commission guidance.

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.

MIKE DIAMOND
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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