



**Mental Welfare Commission for Scotland**

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

**Date of visit:** 3 May 2017

## **Where we visited**

Surehaven is a low secure, private psychiatric hospital. It has been open for six years. The facility was extended in 2015, increasing bed numbers from 17 to 21. There are two wards: Campsie ward for female patients and Kelvin ward for males.

Patients are referred from health boards across Scotland when care in a low secure setting is required but facilities may not be available locally. On the day of our visit there were 20 inpatients, one patient having recently been discharged, with six individuals on the waiting list.

We last visited this service on 5 December 2016 as part of the Commission's national themed visit to low and medium secure care in Scotland. Prior to this, the last local visit to Surehaven was an announced visit on 6 January 2016. At this time we made recommendations regarding the recording of multidisciplinary team meetings (MDTs); consultant reviews; consent to treatment; and environmental upgrades.

On the day of this visit we wanted to follow up on these previous recommendations. We also wanted to look at enhanced observations and the treatment available for patients with borderline personality disorder (BPD). This is because the themed visit identified a number of patients on enhanced observations for prolonged periods, and an increasing number of female patients being transferred for treatment of complex BPD under the Mental Health Act (MHA).

## **Who we met with**

We met with and reviewed the care and treatment of 10 patients and spoke with one carer.

We met with the service manager, deputy service manager, consultant psychiatrist and nursing staff.

## **Commission visitors**

Jamie Aarons, Social Work Officer

Dr Stephen Anderson, Commission Consultant Psychiatrist

Dr Juliet Brock, Medical Officer

Mary Leroy, Nursing Officer

## **What people told us and what we found**

### **Care, treatment, support and participation**

The patients we met with generally spoke positively about their care and gave much praise to the nursing team, describing staff as supportive and willing to “go the extra mile” for their care.

The carer we spoke with was also highly complementary about the care their family member was receiving. Indeed in their view, the clinical team had “saved the life” of their loved one, who had been very unwell at the point of admission.

As on previous visits, patients spoke positively of their opportunity to raise issues at the weekly community meetings, telling us their suggestions were heard and did often influence change.

A number of patients did however inform us that they were not being invited to their MDT meetings and did not meet with their consultant psychiatrist on a regular basis. This has been raised as an issue with the Commission during our last two visits. The hospital’s action plan following our January 2016 visit indicated that policies were being reviewed and that both MDT meetings and consultant reviews were being audited.

New hospital policy is that patients are to be seen by their consultant psychiatrist at least once a month. It was explained to us that this is a minimum requirement and the expectation is that patients are seen more frequently, preferably weekly at the MDT.

We were informed by managers and the consultant psychiatrist that this standard is being met and that many patients are, in fact, being seen on a weekly basis. It was not possible to reconcile this account with the narrative of a number of patients we met. We return to this issue in the documentation section below.

### **Documentation and care plans**

In the patient files we reviewed, we found nursing care plans to be person centred, with good evidence of patient involvement in reviews, indicating a collaborative approach. We also found clear and informative records of occupational therapy (OT) and psychology input in the notes.

Reviewing the weekly MDT forms, we found some improvements since our last visit. Nursing staff were completing their part and writing weekly summaries prior to the meeting. This gave an indication of each patient’s progress, and highlighted any new risks or particular issues for discussion. However, in the files we reviewed, we found that documentation of the MDT discussion itself remained lacking.

It was still very difficult to determine whether the patient had a) been invited to the meeting, b) had attended, and c) the content of any discussion with the patient if they had attended. This section of the MDT form was frequently left blank. Details of patient attendance was not, therefore, available to inform the monthly charge nurse audits.

It was also difficult to determine from the MDT form what the ongoing rehabilitation/treatment plan was for each patient.

These issues have been a consistent criticism by the Commission since 2014.

As stated in our last report in January 2016, a significant number of the patient group are in hospital for a long period and are, for the most part, relatively stable, however regular review by the inpatient team remains an important aspect of their weekly care.

We noted again on this visit that the consultant usually makes a separate entry in the medical notes in respect of the MDT meeting and discussion. However, we found this content to be minimal. In the files we reviewed, there was little or no reference in the medical entries to an assessment of the patient or their mental state, their treatment, ongoing rehabilitation plan or to any decisions resulting from the review. It was not clear from most medical entries whether or not the patient had been seen in person by the consultant.

The monthly summaries, although multidisciplinary and detailed overall, also appeared to lack a clear psychiatric summary and ongoing plan for each patient.

We are therefore repeating a number of our previous visit recommendations. As such, we will require a clear and detailed action plan in response, including targets and timescales for recommendations 1-3 below. The Commission will be requesting quarterly monitoring data on each of these actions over the next year.

**Recommendation 1:**

Charge nurses must ensure that every patient is invited to the weekly MDT meeting. Patient attendance should be recorded on the MDT form alongside a summary of any discussion with the patient. If a patient declines to attend the MDT, the reasons for this should be recorded. If a patient repeatedly declines to attend, they should be given other opportunities to meet their psychiatrist and discuss their care.

**Recommendation 2:**

Hospital managers should devise a system to accurately audit patient attendance at MDT meetings. Outcomes should be monitored to inform clinical practice and improve standards.

### **Recommendation 3:**

Hospital managers should ensure that the standards set out in their policy for psychiatric review are being met.

### **Recommendation 4:**

The consultant psychiatrist and hospital managers should ensure that medical entries in patient notes meet current standards of record keeping, as set out by the Royal College of Psychiatrists (Good Psychiatric Practice, CR154; p12 no.14) and the GMC (Guide to Good Medical Practice; para 19-21).

When we reviewed the monthly charge nurse audits, we noted these were extremely lengthy. The time required to complete them would undoubtedly be onerous, which may partly explain why they were often incomplete and sometimes absent. The clinical purpose of all the data collected was not always clear. We encourage the use of audit as a valuable tool to improve standards of care. The National Institute for Health and Care Excellence (NICE) defines audit as “a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change” (NICE, 2002). The hospital managers and charge nurses may find it useful to review and refine what information is collected in the monthly audits. This may help make the task itself more manageable for the charge nurses, and ensure that the information gathered is relevant, meaningful and clearly linked to quality improvement.

### **Use of mental health and incapacity legislation**

We found MHA documentation present and easy to navigate in patient files. We also found copies of certificates authorising medical treatment (T2 and T3 forms) filed alongside each patient’s medication chart, enabling easy checking and reference to be made.

We reviewed the T2 and T3 certificates for all current patients. This was an area for improvement highlighted in previous reports.

For patients who had consented to their medication, we found appropriate T2 certificates present.

For patients who had refused treatment, not all had authorisation of treatment certificates (T3s) completed by a second opinion doctor (a designated medical practitioner, DMP) as required in the MHA. We found four cases where patients were prescribed injectable medication that was not authorised on a T3 form.

A number of patients were prescribed the oral antipsychotic Clozapine, but accompanying monitoring sheets were not complete or kept up to date. We also found

one patient prescription chart where no route of administration was specified for the medications prescribed.

All the above individual issues were highlighted with the consultant psychiatrist and hospital manager on the day for urgent action to be taken.

#### **Recommendation 5:**

We repeat again our previous recommendation that hospital managers should have systems in place to check that certificates authorising medication (T2 and T3 forms) are regularly reviewed and audited for accuracy, to ensure that medication given is properly authorised.

#### **Recommendation 6:**

Hospital managers should ensure that appropriate monitoring is carried out, and recorded, for each patient prescribed Clozapine, in accordance with current Scottish Government guidelines:

[http://www.sehd.scot.nhs.uk/cmo/CMO\(2017\)04.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2017)04.pdf).

### **Rights and restrictions**

At this visit, two patients were being nursed on constant observations, one having been on this high level of monitoring for over a year. We discussed these individual cases with the clinical team and underlined the importance of regular reviews, combined with updated risk assessments, to ensure that patients receive care in the least restrictive way possible.

We noted that all patients had a 'patient rights/advance statement' monitoring sheet in their notes which was updated monthly.

We discussed advocacy services and noted that some patients, especially in Kelvin ward, did not appear to access advocacy support. Currently advocacy is arranged on an 'as requested' basis for individual patients. It was recognised that some patients may need more support and prompts to request this. We discussed how the service might support the patient group in accessing advocacy, including models used in other services where an 'advocacy clinic' is run on a regular basis. Hospital managers plan to consider what option is most appropriate for Surehaven.

On a separate rights matter, we were made aware that there are 36 security cameras currently sited around the hospital. These include cameras in communal clinical areas on the wards, but not patient rooms or private spaces. Managers informed us that 32 of these cameras are connected but that content is not actively monitored. We were advised that recordings are only used on rare occasions and this is done retrospectively, either for the purpose of staff education or to provide evidence relating

to untoward incidents. In one instance this led to the hospital taking action against a member of staff when a patient had been mistreated. Managers informed us that staff are aware of this and that information regarding security cameras is provided in patient admission packs.

### **Recommendation 7:**

Hospital managers should ensure that arrangements are in place for ready access to advocacy services and that staff encourage and support patients to engage.

### **Activity and occupation**

Patients we met with were generally positive about the activities and groups on offer. The carer we spoke with was also very positive about access to a wide range of activities for patients on the ward. They told us this level of occupation continued to have a very positive impact on the recovery of their family member.

The hospital has two activity co-ordinators and two OTs, shared between the wards. We found a good range of activities on offer, both in groups within the hospital (such as art groups, cooking, gardening and life skills) and outside (walking groups, football and an allotment). A weekly swimming group and equine therapy at a local stable are also on offer.

At weekends, activities are led by ward staff. Escorted visits and outings are also arranged for those able to participate. Social activities and events which friends and family are encouraged to attend, such as a summer barbecue, are also arranged periodically.

### **The physical environment**

We were pleased to see that significant improvements have been made to the ward environments over the past year, particularly on Kelvin ward. Communal areas have been re-painted, flooring has largely been replaced where required and the wards had a much brighter and more welcoming appearance. There are more pictures and patient artworks on the walls, providing more visual interest in communal areas. Individual rooms are also clearly personalised by each patient, providing a homely atmosphere.

One of the group rooms has been converted to a small gym with a running machine and weights. We were told that this is used regularly by patients, especially on the male ward, and that members of staff who are qualified personal trainers help develop individual fitness plans.

The main environmental issues for ongoing improvement are the flooring in the male shared bathroom (which has become heavily stained) and the garden area accessed by Kelvin ward, which remains somewhat barren. We were pleased however to hear

of plans to transform the space over the summer and we look forward to seeing improvements on future visits.

## **Any other comments**

### **Training**

As noted earlier, an increasing number of patients with a primary diagnosis of borderline personality disorder (BPD) are now being referred to Surehaven and receive prolonged periods of inpatient low secure care.

We were keen to hear more about the treatment philosophy on the unit for this patient group, who often have complex needs.

We learned that the hospital's clinical psychologist had recently left. A new clinical psychologist is shortly due to start 1.5 days a week, with a new post also created for a counselling psychologist. From our discussions with the clinical team and managers, a clear therapeutic model for working with BPD patients has not yet been established. No staff are currently trained in mentalisation based therapy (MBT), dialectical behavioural therapy (DBT) or other recognised approaches.

We heard accounts on this visit, both from patients and from ward staff, which emphasised the importance of a consistent therapeutic model of care.

The Scottish Intercollegiate Guidelines Network (SIGN) have not yet published clinical guidelines on BPD care. However, NICE published their guideline CG98 'Borderline Personality disorder: recognition and management' in 2009 and reviewed this in 2015. This guideline makes recommendations for training, supervision and support:

*1.1.9.1 Mental health professionals working in secondary care services, including community-based services and teams, CAMHS and inpatient services, should be trained to diagnose borderline personality disorder, assess risk and need, and provide treatment and management in accordance with this guideline..... Training should be provided by specialist personality disorder teams based in mental health trusts (see [recommendation 1.5.1.1](#)).*

*1.1.9.2 Mental health professionals working with people with borderline personality disorder should have routine access to supervision and staff support.*

We recognise that, as an independent hospital, Surehaven would not ordinarily have access to training from specialist personality disorder teams in the local NHS trust. However, it is important that appropriate training, supervision and support, is in place for staff and that care is provided in accordance with recognised guidelines.



Given that patients at Surehaven are receiving care and treatment under the MHA, the principle of reciprocity is particularly important.

It may be helpful for hospital managers to consider the following guidance on 'Key Priorities for Implementation' in the NICE guideline (p9):

### **The role of psychological treatment**

- *When providing psychological treatment for people with borderline personality disorder, especially those with multiple comorbidities and/or severe impairment, the following service characteristics should be in place:*
  - *an explicit and integrated theoretical approach used by both the treatment team and the therapist, which is shared with the service user*
  - *structured care in accordance with this guideline*
  - *provision for therapist supervision.*

### **Recommendation 8:**

Hospital managers should ensure that an integrated approach is developed for the psychological treatment of inpatients with borderline personality disorder in accordance with current clinical guidelines. This should include arrangements for staff training, supervision and support across the clinical team.

### **Summary of recommendations**

1. Charge nurses must ensure that every patient is invited to the weekly MDT meeting. Patient attendance should be recorded on the MDT form alongside a summary of any discussion with the patient. If a patient declines to attend the MDT, the reasons for this should be recorded. If a patient repeatedly declines to attend, they should be given other opportunities to meet their psychiatrist and discuss their care.
2. Hospital managers should devise a system to accurately audit patient attendance at MDT meetings. Outcomes should be monitored to inform clinical practice and improve standards.
3. Hospital managers should ensure that the standards set out in their policy for psychiatric review are being met.
4. The consultant psychiatrist and hospital managers should ensure that medical entries in patient notes meet current standards of record-keeping, as set out by the Royal College of Psychiatrists (Good Psychiatric Practice, CR154; p12 no.14) and the GMC (Guide to Good Medical Practice; para 19-21).
5. We repeat again our previous recommendation that hospital managers should have systems in place to check that certificates authorising medication (T2 and

T3 forms) are regularly reviewed and audited for accuracy, to ensure that medication given is properly authorised.

6. Hospital managers should ensure that appropriate monitoring is carried out - and recorded - for each patient prescribed Clozapine, in accordance with current Scottish Government guidelines:

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7. Hospital managers should ensure that arrangements are in place for ready access to advocacy services and that staff encourage and support patients to engage.
8. Hospital managers should ensure that an integrated approach is developed for the psychological treatment of inpatients with borderline personality disorder, in accordance with current clinical guidelines. This should include arrangements for staff training, supervision and support across the clinical team.

## **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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