Mental Welfare Commission for Scotland

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

Date of visit: 14 January 2025

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 females, and Kelvin Ward accommodates 15 males. The layout of the hospital, and facilities were unchanged since our previous visit in January 2024. On the day of our visit there was one vacant bed which was due to be filled that day by a new admission to the hospital.

Low secure forensic wards generally have a higher ratio of staff 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.

Our last visit to the service was announced and we made recommendations regarding the need to ensure that section 47 certificates completed under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) included treatment plans and that a programme of work was put in place to address the environmental issues we discovered on the day of the visit.

The response we received from the service was that the consultant psychiatrist for the hospital was completing individualised treatment plans for all the section 47 certificates.

We were advised that a programme of work had commenced, with an action plan in place, to ensure environmental standards were being met appropriately with weekly environmental walk-rounds in place.

On the day of the visit, we wanted to give individuals and their relatives an opportunity to speak with us regarding the care and treatment on offer. 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

We met with four individuals and reviewed the care notes of seven individuals. We met with two relatives.

We spoke with the general manager, the clinical nurse manager, the lead nurses for the wards, the consultant psychiatrist, the occupational therapy (OT) lead, the psychologist and nursing staff.

We had the opportunity to observe individuals taking part in group activities in the wards and our engagement and participation officer was able to attend lunch with individuals in Kelvin Ward.

Commission visitors

Justin McNicholl, senior manager (projects)/social work officer

Paul Macquire, nursing officer

Gemma Maguire, social work officer

Graham Morgan, engagement and participation officer (lived experience)

What people told us and what we found

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 review the plans for individuals who had been in the hospital for several years and the plans in place that would support them to prepare for discharge.

Individuals told us that, “the staff are great; they take time to be with us and take us out of the unit”. There were a number of positive comments from individuals that they felt they could “trust staff”, that they were “very sweet”. We received comments that “the doctor is very good; he is good at listening”. This was echoed by another individual who stated, “the doctor is nice and good”. One person described having a say in what they do each day, and they noted that this was very important to them compared to their previous experience in another hospital.

We were keen to know whether individuals felt part of their recovery journey, and equal partners in their care and treatment. We were informed individuals were invited and welcomed into the multidisciplinary team (MDT) meetings and their views were actively sought. We saw in the MDT meeting records evidence of participation and for some, negotiated outcomes that the individual held responsibility for. We heard from some that “it’s okay here” and the food is “fine”.

We heard how individuals were regularly supported to maintain contact with their family members. The relatives we spoke with described being “terrified” that their son or daughter would lose out on the “terrific” support offered by the hospital staff. We heard from individuals that additional steps were taken to maintain contact with their children whilst inpatients in the hospital.

Most staff members we spoke with knew the individuals on the ward 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 care plan goals.

We noted similar to our last visit that the majority of the individuals 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 individuals were not keen to participate in activities, there were strategies in place to motivate and engage them, with noted success.

We met with the newly appointed psychologist to the hospital. The psychologist had been facilitating mindfulness and relaxation groups for individuals in the hospital, as well as building up rapport with individuals in each of the wards, with plans to introduce one-to-one sessions in the coming months. We heard of work that had

been undertaken by the psychologist to provide reflective practice groups for the staff which aimed to support staff and benefit individuals' care and treatment goals. We look forward to hearing how this will impact on care during our next visit. The hospital continued to employ an independent forensic psychologist who completed the Historical, Clinical and Risk Management-20 (HCR-20) reports.

The OT lead for the hospital advised us of the work undertaken via the carers group to engage relatives of the individuals in the hospital. This included the adoption of the 'triangle of care' model and a carers charter. The 'triangle of care' is a therapeutic alliance between carers, individuals and health professionals. It aims to promote safety and recovery and to sustain mental wellbeing by including and supporting carers. The Carers Charter was introduced by the Scottish Government to help make carers aware of their rights under the Carers (Scotland) Act, 2016. The OT staff ensured that twice yearly engagement sessions were held at the hospital to provide carers with an oversight of developments and to meet with their relatives in a relaxed setting during seasonal events, including summer and Christmas events.

All the individuals we spoke with indicated that they had regular access to the community to undertake activities that they enjoyed. Two individuals commented; "I like the walks to the canal" and "I get out to the canal; it's a great place to go". We heard of visits to the local shops, larger retail outlets and other regular walks in the community that individuals found beneficial. On the day of the visit individuals were being accompanied by the OT assistant's dog for a walk which appeared to provide positive outcomes for those who participated in the session.

We heard from managers that similar to our last visit, recruitment and retention of nursing staff was not currently a challenge. It remained positive to note that there were no agency staff utilised by the hospital, which had helped to provide consistent care and treatment.

Care, treatment, support, and participation

Nursing care plans

Nursing care plans are a tool that identify detailed plans of nursing care and intervention; effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made. We found that individuals in the hospital had care and treatment plans in place to support outcomes and identified plans of nursing care. These were stored in paper files held in each of the wards. Similar to our previous visits, we had no concerns with the quality of the care plans; we found them to be comprehensive, with a clear focus on risks, with regular reviews in place.

We found that individuals had multiple plans to support their care and treatment in the hospital. The information in these plans detailed the care, treatment and support

the individual required, providing a clear understanding to staff as to what nursing interventions were necessary to provide the support required. We found up-to-date care plan reviews providing clear information on individuals' progress towards agreed goals, including discharge planning. It was positive to note that these have been maintained since our last visit to the hospital.

Participation

We heard that individuals were encouraged and supported with all aspects of their care. We heard of the fortnightly community meetings attended by staff which took place in both Campsie and Kelvin Wards. During these meetings, individuals were encouraged to discuss any concerns about the hospital and to offer suggestions for therapeutic activities, future themed projects or improvements. We heard how individuals could meet with the chef to discuss their dietary preferences and how the hospital sought to deliver on these preferences.

We observed and found evidence of those that had difficulty engaging in aspects of their care and treatment or who lacked capacity to make certain decisions and how they were always encouraged and supported. The care we observed ensured that there were shared opportunities for person-centred interventions, that individuals were participating and their will and preferences were acknowledged and prioritised. For example, we observed one individual who liked to spend time at the nurses' station and this was supported while ensuring that other individuals' confidentiality was not compromised.

We heard from the care team that there was a sustained level of stability in those receiving care and treatment in Surehaven. This was noted at times to be frustrating for staff and managers. As noted in our previous report, Surehaven remains out with the framework of delayed discharge procedures that applies to NHS hospitals. This lack of delayed discharge procedures causes significant delays by health and social partnerships (HSCPs) in prioritising and ensuring swift moves for those who were deemed clinically fit for discharge or inappropriately placed in the hospital. We have spent considerable time over the last year continuing to engage with HSCPs to highlight individuals' circumstances that have required priority to find appropriate placements for them in the community or alternative hospital placements. We found evidence that despite these delays, individuals were being supported to ensure their rights were protected and they were advocated for.

When reviewing the care records, we found that each individual had a personal story which should be completed by the individual or their relatives. Some of the those we reviewed were not completed, while for others, some of the content was illegible. The importance of this document and ones similar to it, such as the 'Getting to Know Me' (GTKM) helps to inform staff who may not know the individual, how best to work them. During our visits, we see the benefit of these documents being completed.

Recommendation 1:
Managers should ensure that all personal story documents are completed, and the content is legible.

Care records
All care records, including care plans, MDT records and risk assessments, were accessible in paper files. The paper files were divided into sections and were easy to navigate. We found daily notes to be at times brief and somewhat repetitive. This was particularly apparent for those individuals on the ward who were considered challenging to engage with due their significant mental ill health. We believe that more meaningful daily records would help to address the steps taken to motivate and engage with these individuals as we found proactive evidence of this on the visit, with evidence of the steps taken by staff to do this. We would like to have seen a more detailed narrative in the daily notes. We brought this to the attention of the managers on the day of the visit.

There was clear and consistent recorded evidence of risk assessment and risk management. The risk assessments in the wards were completed to a high standard, which included detailed HCR -20 reports, as well as use of the care programme approach (CPA) which assisted individuals moving out of the low secure wards when deemed appropriate. CPA is the structured process for the care and treatment planning of individuals and the management of risk.

We found evidence of the 'model of human occupation screening tool' (MOHOST) and OT reports on file for those individuals who required this level of assessment. These reports were clear and detailed evidence of engagement and participation, where possible, by the individuals involved.

Multidisciplinary team (MDT)
We were pleased to note that both wards continued to have a full MDT that met in person on a weekly basis and included psychiatry, nursing, OT, psychology and other staff as and when required.

The recording of the MDT meetings was found to be consistent, with evidence of engagement and participation by individuals, and where appropriate, their named person and their relatives. We found evidence of steps taken before the MDT meeting to ensure views are gathered, considered and if required, actioned at the meeting. Of the records we reviewed, there was a record of the attendance by social workers, mental health officers and other external professionals, where required.

When reviewing the MDT meeting records, we found that only the initials of the staff present were recorded, meaning it was not clear who these staff members were or their job titles. We are recommending that steps are taken to improve this area of recording.

Recommendation 2:
Managers should ensure that all MDT meeting records include the full name and designation of all in attendance.

Although some of the MDT notes were brief, there was evidence of the decisions made at these meetings. It was not always clear who was responsible for each action, but we could see from the records that these matters were progressed from week to week.

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, whilst a private general practitioner visited the hospital on a regular basis.

Use of mental health and incapacity legislation

On the day of our visit, all 20 of those 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 (Criminal Procedure Act), as we would expect in a low secure setting. Most of the orders in place were under the Mental Health Act. The appropriate detention paperwork was readily available.

Most of the documentation relating to the Mental Health Act, the Criminal Procedure Act and Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) were in place in the paper files.

Anyone who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a named person had been nominated a named person, we found this was clearly recorded in the individuals' care records.

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 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 some section 47 certificates in the individual paper files had expired.

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 person. 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 person has capacity to make decisions regarding their healthcare needs. Unfortunately, despite the recommendation from our last visit, we found no treatment plans attached to the section 47 certificates that we reviewed. We discussed this with the lead consultant psychiatrist on the day who agreed to address this gap in recording and have restated this recommendation again for this visit.

Recommendation 3:
Medical staff must ensure that up to date section 47 certificates and their associated treatment plans are completed and filed in the case records of all individuals who require them.

We discussed this further with the nursing staff on duty and we found that there were gaps in their understanding around the implementation of the AWI Act duties including how section 47 certificates, powers or attorney and guardianships order impact upon day-to-day decision making for individuals.

This was further evidenced by staff not always being clear on where these documents were located and how the existence of these forms had an impact on nursing responsibilities, as opposed to the duty of the lead medic for the ward(s). We are clear that it is imperative that every staff member in a clinical setting understands how the AWI Act impacts their role and duties.

The Commission has worked jointly with NHS Education for Scotland (NES) to develop training in relation to the AWI Act and an eLearning module has been launched on TURAS. This can be accessed by anyone in the workforce and has been developed for those working with people aged 16+ years who may be considered to lack capacity to make some or all decisions.

Recommendation 4:
Managers should take steps to improve staff understanding and training in relation to the AWI Act. We recommend the eLearning module on TURAS, which has been developed for informed and skilled levels of practice within the workforce.

Rights and restrictions

Surehaven continued to operate a locked door, commensurate with the level of risk identified with the individuals in the hospital. The restrictions that were in place were understood by those that we spoke with. Almost all of the individuals in the hospital 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. No individuals were subject to enhanced observations on the day of our visit.

All of the individuals that we spoke to had a good knowledge of their legal status and rights; they knew how to access this service, as well as legal representation or had access to support from advocacy and legal representation.

When we are reviewing individuals' files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 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 copies of advance statements in the records we reviewed. Similar to our last visit we found evidence of when individuals 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 someone is made 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 seven people on the day of our visit who were subject to restrictions. We were told that these arrangements were 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 records. We saw evidence of these forms during the visit but none of the RES1 or RES3 forms had any reasoned opinions attached. We found no evidence that the individuals had been written to by their psychiatrist to inform them of their rights to appeal their specified person status. We are restating this recommendation.

Recommendation 5:
Medical staff must ensure that when specified person measures are put in place, reasoned opinions are completed, and filed in the care records

We discussed the need to complete reasoned opinions and to formally write to the individuals about their restrictions with the psychiatrist on the day. Due to this appearing as a consistent issue in the last three years we are recommending that multidisciplinary training is put place for the application and use of specified persons. The Commission has produced good practice guidance on specified persons[1].

[1] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512

Recommendation 6:
Managers should ensure that all staff are trained on the application of specified persons procedures.

As noted on previous visits, closed-circuit TV (CCTV) remained in place across all the communal areas of the wards. There were no cameras in the bedrooms, toilets, showers or bathrooms. We heard no concerns from staff or individuals on the use of CCTV throughout the hospital.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

We heard from individuals and staff in the hospital regarding the wide variety of activities available. This included art, singing, baking, games, yoga, movie nights, walking and various other recreational activities. Much of this work was led by OT staff who had access a therapy kitchen which promoted healthy eating.

It was positive to see that similar to our last visit, there remained a wide variety of meaningful activities arranged in partnership between individuals and staff. During our review of the care records, we did not see specific evidence of the recording of these activities. We believe this could be better detailed by staff and this was shared with managers on the day.

As noted in our last visit to Surehaven, unlike many other low secure facilities, most individuals had access to their own phones and or tablets for internet (subject to individual risk assessments) usage. This access was noted to be of benefit, as people could maintain regular communication with their families and access online entertainment.

The physical environment

The layout of the hospital remained unchanged since our last visit. There were three separate garden areas which appeared safe and provided privacy. One of the garden areas was regularly used for individuals to meet with their relatives. There were communal benches in place to allow people to sit and relax. We were told that the garden area was popular with individuals and visitors alike.

People continued to have access to their own individual en-suite bedroom which they were encouraged to personalise with their own belongings.

During our visit, the ward atmosphere was calm. As discussed at our last visit, there remain plans to extend the hospital, creating a further 12 rehabilitation beds and

[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

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 people requiring this type of specialist care. The work is due to be completed by April 2026. We look forward to visiting and reviewing the impact these adjustments will make to care and treatment.

Whilst undertaking a tour of Kelvin Ward we found a significant malodorous smell coming from one of the bedrooms which was being allocated to a new admission. Once highlighted, steps were taken by staff to address the odour, we reviewed this matter later in the day and it had been addressed. Compared to our last visit, we found no evidence of repairs that required addressing this time.

Any other comments

We received a copy of the hospital newsletter which demonstrated various work undertaken by the staff to promote positive wellbeing. The newsletter displayed individual artwork as well as various social opportunities, reflective themes and events which have occurred over the last three months. We view this as a positive means to communicate effectively with individuals and the wider staff group.

Summary of recommendations

Recommendation 1:
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Recommendation 2:
Managers should ensure that all MDT meeting records include the full name and designation of all in attendance.

Recommendation 3:
Medical staff must ensure that up to date section 47 certificates and their associated treatment plans are completed and filed in the case records of all individuals who require them.

Recommendation 4:
Managers should take steps to improve staff understanding and training in relation to the AWI Act. We recommend the eLearning module on TURAS, which has been developed for informed and skilled levels of practice within the workforce.

Recommendation 5:
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Recommendation 6:
Medical staff should ensure that when specified person measures are put in place, reasoned opinions are completed, and filed in the care records

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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 an individual's care, treatment, and support are 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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