**Mental Welfare Commission for Scotland**

**Report on announced visit to:**
Radernie Low Secure Unit, Stratheden Hospital, Springfield, Cupar, Fife KY15 5RR

**Date of visit:** 22 August 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.

Radernie Unit is a low secure forensic ward based in the grounds of Stratheden Hospital in Fife. It is a male-only facility and can accommodate up to 10 patients. Patients in a low secure setting are more likely to have been subject to court proceedings, or may not have been able to be safely cared for in adult mental health services.

We last visited this service on 19 September 2019 and made a recommendation that managers keep the issue of delayed discharges under review and work with social care partners to progress these.

On the day of this visit we wanted to follow up on the previous recommendation and also to hear how patients and staff have managed throughout the Covid-19 pandemic and any possible limitations this has posed for carers visiting their relatives. We were keen to hear from staff how they had adapted their usual ways of working to meet the needs of their patients and with the restrictions imposed during the height of the pandemic. We heard that there were a number of restrictions required to ensure patients were not adversely affected by Covid-19. With visitors to the ward limited, the ward-based team supported patients to maintain contact with relatives by using technology for example with support from staff to used ward based computers.

## Who we met with

We met with, and reviewed the care of, four patients. No patient's relatives requested to speak with us on the day of the visit; however we had asked that nursing staff advised relatives that if they would like to speak with the visiting team at a later date, this would be arranged.

We spoke with the service manager, lead psychiatrist and charge nurse prior to the day of our visit and met the senior charge nurse and lead nurse on the day of our visit.

## Commission visitors

Anne Buchanan, nursing officer
Lesley Paterson, senior manager, west team (practitioners)

# What people told us and what we found

## Care, treatment, support and participation

Patients admitted to Radernie typically require a higher level of restrictions than individual in the general adult mental health population. This is because they may have transferred from courts, prisons or intensive psychiatric care settings. With this level of restriction required, we would expect care and treatment to meet the needs of individuals, who by virtue of their presentations, will need intensive support to ensure they are given opportunities to live independently, when their road to recovery will enable this. All patients in Radernie are subject to enhanced Care Programme Approach (CPA) reviews, which is a multidisciplinary care management system. There was evidence of patients, relatives, the immediate care team and allied health professionals participating in these meetings. We were pleased to see that there was regular communication with social care partners, including social workers and mental health officers. As identified in our last visit, we were told there has been very little progress with patients moving on from hospital back into their communities. We were told this is an ongoing source of frustration for everyone involved however most notably for the patients themselves. We asked about the specific barriers that prevented patients moving on from hospital and we heard it is typically in relation to finding suitable tenancies and importantly suitable care and support providers. Allocation of tenancies and packages of care to support individuals to live successfully in their community post-discharge from hospital has continued to be a significant challenge. For those individuals whose discharge from hospital has been delayed, their ability to engage with ongoing rehabilitation is hindered and we were told from patients they experience constant uncertainty of their future out with the hospital setting.

### Care plans and patient records

Patient's notes are recorded in the electronic care recording system, MORSE; we found this system easy to navigate. We were keen to review care plans, multi-disciplinary team (MDT) minutes from weekly review meetings and day-to-day progress notes. While this electronic system lends itself to easy access for the MDT to update information, it was difficult to locate the patients' views of their care and treatment. For example, there was little evidence of one-to-one meetings with patients. We would expect to see regular reviews with individual patients and outcomes from those reviews documented within each patient's notes.

Care plans were regularly reviewed however, there was little evidence of participation with patients to understand whether goals and interventions had been agreed or were successful. To ensure participation and supported decision making, nurses should be able to evidence how they have made efforts to do this and that actions that are part of a care plan are clear and attainable. We were told by staff that Radernie has a focus upon rehabilitation for their patient population, however with a continued staffing shortfall, this has had a significant impact on the work that can be undertaken to support patients and their recovery. We were told the Covid-19 pandemic has also impacted upon patients' access to community placements for therapeutic and recreational activity. Staff had hoped non-statutory organisations would have input into the ward in an attempt to strengthen patient's participation with community supports services and to assist with activities in the ward, however this has yet to happen. The ward's senior leadership team remain hopeful this intention will be progressed in the future.

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 carry out an audit of the nursing care plan reviews to ensure they fully reflect patient participation, the patients' progress towards stated care goals, and that the recording of reviews are consistent across all care plans.

We were keen to understand how Radernie staff promote physical and mental well-being. We recognise that patients who have been in hospital for a considerable length of time may need additional support to ensure their physical health is monitored and that opportunities are given for exercise, healthy dietary options and outdoor activities. We were concerned to see the majority of patient's access to, and intake of, fizzy drinks. We observed patients walking around or sitting in the ward drinking from large bottles of fizzy drinks, with empty bottles left on the floors in various rooms. There were also a significant number of full bottles stored in the ward's kitchen. We were told by staff that patients will order their fizzy drinks and various snacks, including sweet snacks from a local online service. The snacks will be delivered to the ward and stored in the kitchen. Staff have attempted to support patients to reduce their 'snacking' however we were told by the leadership team it has been difficult as there is little in the way of alternatives to reduce boredom in the ward. We also noted when reviewing patient's prescriptions there were a significant number of 'as required' medications administered as patients were regularly presenting with 'agitation'. We spoke with staff to understand whether there could be a correlation between patients consuming considerable amounts of fizzy drinks and levels of agitation. We asked whether this could be reviewed in relation to staff working with patients, to promote their physical health and mental well-being.

**Recommendation 2:**
Managers should review patients physical health and well-being, consider whether current access and availability of snacks and fizzy drinks could be moderated to promote healthy choices and reduce any associated risks.

There are a number of patients who have been in this ward for a considerable length of time. Six of the 10 patients currently in Radernie are considered delayed discharges. We were told this is due to the complexity of their needs and the challenge in finding services to support those individuals who will require a higher level of support and likely supervision following discharge from hospital. Additionally, there is accommodation called Chestnut Lodge based in the hospital grounds for two patients who are supported by staff from Radernie Unit. This accommodation offers semi-independent living for patients nearing discharge from hospital. Patients living in Chestnut Lodge have nursing staff available should they require support, however the level of restrictions for those patients is lower and they are supported to develop skills for living independently in the community. We heard that a further issue that is adding to the delay is with allocating tenancies and finding support packages for patients who are ready for discharge from hospital back into the community.

This ongoing issue not only impacts on patients and their hope for returning to their communities but also places a limit on the number of patients who can be admitted to Radernie from courts, prisons and intensive psychiatric care settings. We were told this ongoing situation creates 'bottlenecks' in other wards, as patients are unable to be transferred to Radernie which compromises their rehabilitation and recovery. We were told Fife Health and Social Care Partnership (HSCP) have initiated a housing / care priority working group to look specifically at this issues. We remain concerned as there has been little progress with this since our last visit; patients who are considered ready for discharge from this ward are disproportionately affected by the lack of appropriate housing and community support provision.

**Recommendation 3:**
Managers should continue to keep the issue of delayed discharges under review and as a matter of immediate attention, consider whether patients who are ready for discharge could be supported in alternative environments with appropriate support packages.

### Multi-disciplinary input

The unit has a multidisciplinary team (MDT) of nursing staff, psychiatrists, psychologist and allied health professionals including occupational therapy and physiotherapy. Additionally, patients have access to a primary care service provided by a GP, which includes Passport to Health; this is an initiative to meet physical healthcare needs and ensure national screening programmes, specific monitoring and observations are routinely undertaken. Referrals to other services, including speech and language therapy and dietetics, can be made if required. Each patient has a psychological formulation and also a team formulation, which we noted to be helpful tools for staff to understand how individuals can be affected by their mental illness and/or adverse experiences in early childhood. Occupational therapy (OT) is also available for every patient and we found that the OTs in the service have provided a wide range of assessments, support to patients in relation to learning new skills and to help with the transition from hospital to home. On the day of the visit, we wanted to see whether the input from members of the MDT was having a positive impact upon patient's day to day lives. We found that there was a lack of detail in the daily notes therefore it was difficult to assess the extent to which progress for each patient was being achieved. We were told there are weekly review meetings for each patient with carers and relatives actively encouraged to participate should they wish to do so. We would however have liked to have seen evidence of how relatives participate in meetings, their views along with patient's views of progress or concerns and, areas they felt could be improved on.

**Recommendation 4:**
Managers should ensure patients and their relatives are actively encouraged to participate in review meetings and document their views in care records.

## Use of mental health and incapacity legislation

On the day of our visit all patients were subject to either the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or Criminal Procedure (Scotland) Act 1995 (CPA) legislation. The patients we met with during our visit had a good understanding of their detained status. All documentation relating to the Mental Health Act and CPA were available in the patient's electronic files.

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. We found that not all certificates consenting to treatment (T2) or authorising treatment (T3) under the Mental Health Act were in place and some that were in place did not correspond with the medication being prescribed. This means that in some cases, psychotropic medication was being administered without legal authority.

**Recommendation 5:**
Managers and the responsible medical officers must ensure that all psychotropic medication is legally authorised and regular audits should be undertaken to ensure correct legal authorisation is in place.

Any patient 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 patient had nominated a named person, we found copies of this in the patient's file.

## Rights and restrictions

Radernie continues to operate a locked door, commensurate with the level of risk identified with the patient group. The majority of patients have unescorted time away from the ward and this is reviewed regularly by the MDT. Patients we spoke with would have preferred additional time away from the ward and told us that they struggled with the restrictions placed upon them as is required in a low secure setting.

We noted that patients have access to independent advocacy. Currently this provision is not always ward-based, however access can be provided by telephone. Patients can ask for support from advocacy for a range of issues or for support during mental health tribunal hearings. Equally, to ensure patients have access to legal representation nursing staff will support patients to maintain contact with their legal representative. Mental health officers also provide support and guidance in relation to hearings whether related to the Mental Health Act or criminal procedures matters.

Sections 281 to 286 of the MHA provide 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 this, and where restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place under the Mental Health Act, we found the relevant paperwork, including reasoned opinions were in place.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

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

We are aware that during the Covid-19 pandemic, restrictions put in place meant that various activities out with the unit had to be put on hold and that some of the patient group struggled

with this change to their routine. We also heard a number of therapeutic activities had ceased as staff had moved on from their posts. This has meant that music therapy, which had been popular, has stopped. We also heard from patients that whilst they enjoyed some activities available to them, they would like to participate in more therapeutic and recreational activities both in the ward, or outdoors. Nursing staff told us that popular activities, including cooking and baking, have not been available and with the long standing issues with staffing, activities usually undertaken by nursing staff have not been routinely undertaken. Patients we spoke with said they were bored and the days seemed long, with very little to do. While we could see a weekly activity planner held in each patient's care notes, often the planner was not populated with activities.

Radernie does not have a dedicated activities co-ordinator. Nursing staff felt having a member of staff that could focus upon pastimes, hobbies and activities would be beneficial as they appreciate patients need opportunities for one-to-one or group work.

There is gym equipment available in the ward, along with access to an outdoor gym in the hospital grounds. An information technology (IT) suite is also available; as with the gyms, they can be accessed under staff supervision.

**Recommendation 6:**
Managers should review activity provision in Radernie, and consider options for a dedicated activities co-ordinator that would ensure activities that were previously available and popular resume.

## The physical environment

Radernie is situated in the grounds of Stratheden Hospital, having previously been an in-patient ward for older adults. Upon arriving to the ward, the main entrance looks rather neglected with paint peeling from the door and a worn sign giving instructions about how to alert staff upon your arrival. We were aware upon our arrival and on our departure patients congregated around the main entrance to the ward to smoke. We were informed Fife HSCP has implemented a smoke free hospital policy in line with the nation-wide public health programme to reduce the harm from tobacco. Staff told us they are attempting to support patients who do smoke with nicotine replacement therapy, however this had been not as successful as hoped. Furthermore, there were a large number of cigarette ends on the ground with numerous empty fizzy drinks bottles that contributed to a less than favourable first impression for our visit.

The ward itself is bleak, with little in the way of colour or warmth. We noticed the corridors and sitting rooms looked tired and in the need of re-decoration. The communal areas lacked any sense of homeliness and as patients are placed in Radernie for a considerable length of time, we considered that the environment should be more conducive.

All bedrooms are single with only two having en-suite facilities, otherwise all bathrooms are shared. We noticed all of the shower areas had black mould around the fittings, and looked unclean and uninviting. There was an unpleasant odour in all of the bathrooms, toilets and corridors leading to them.

There was access to outdoor space with a garden for patients to use should they wish. Unfortunately, the garden has not been tended to, looks uncared for and did not appear as an inviting space to spend time in.

**Recommendation 7:**
Managers should ensure that outstanding repair and refurbishment work is undertaken and regular environment audits within specific timescales for improvement are agreed.

**Recommendation 8:**
Managers should ensure that the outdoor space available to Radernie is welcoming and attractive for patients and visitors to use.

## Any other comments

We were told by staff that the patients in their ward had a range of complex, individual needs and there were concerns around the extent the staff could provide care and treatment due to the ongoing issues in relation to recruitment and retention of staff. We are aware providing care and treatment for this patient population takes time and expertise. Therapeutic relationships develop over time and without commitment, those relationships could be compromised where there is a lack of sufficient investment and resources, whether those resources are associated with staff, the environment or the availability of community placements.

We heard from staff that they are committed to providing high-quality care to support and enhance their patient's recovery. Moreover, patients should be provided with provisions to move on from hospital based care and successfully live in their own communities, whilst families are reassured that community placements will offer the stability and personalised care that their relatives deserve after what is often a lengthy admission to hospital.

# Summary of recommendations

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## 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.

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