Mental Welfare Commission for Scotland

Report on unannounced visit to:

Radernie Low Secure Unit, Stratheden Hospital, Springfield, Cupar, Fife KY15 5RR

Date of visit: 15 May 2023

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 22 August 2022 and made several recommendations that included care planning, patients and relatives' participation in reviews, physical health and well-being for every patient, authorising treatment in relation to Mental Health Act legislation, activity provision and the environment. We also made a recommendation on our last visit that had previously been highlighted to the service and that was in relation to the number of individuals who had been considered ready for discharge however there were considerable delays in securing appropriate tenancies and packages of care. While there were several patients who still experienced delays, we were pleased to hear that a number of individuals had been discharged from the ward and of the patients that were still waiting, there were preparations underway for a return to community placements.

As this was an unannounced visit to Radernie Unit, we were unable to meet with patient's relatives on the day however, we informed the ward-based team we would be happy to have contact from relatives following the visit and provided our contact details.

Who we met with

We met with, and reviewed the care of seven patients, four who we met with in person and three who we reviewed the care notes of.

We spoke with the service manager, the senior charge nurse, charge nurse, consultant psychiatrist, psychologists, and occupational therapist.

Commission visitors

Anne Buchanan, nursing officer

Lesley Paterson, senior manager (practitioners)

Gordon McNelis, nursing officer

What people told us and what we found

Care, treatment, support and participation

On the day of the visit, there were eight patients in Radernie Unit. In addition, there were a further two patients accommodated in Chestnut Lodge. This accommodation is based in the hospital grounds and offers semi-independent living for patients nearing discharge from hospital. Patients living in Chestnut Lodge were supported by staff from Radernie Unit, however the level of restrictions for those patients was lower and they were supported to develop skills for living independently in the community.

We were keen to meet with patients on the day of the visit; we were aware from our last visit that there had been some frustrations in relation to delays in moving on from hospital-based care to community placements and a lack of therapeutic and recreational activity. On the day of the visit, we spoke with four patients, all of whom were largely positive about their care and treatment. They welcomed the input from allied health professionals, including occupational therapy and psychology. There remained a sense of them missing consistent one-to-one engagement with nursing and medical staff. Patients valued their relationships with the nursing team and told us they would welcome more opportunities for one-to-one sessions. Overall, patients told us they felt nursing staff were approachable and were keen to aid patients' recovery. During our conversations with patients, we asked how safe they felt on the ward and if there were any issues, who they would approach to discuss those concerns. Patients told us they felt safe most of the time, but there were occasions where relationships with peers could be strained, however in the main, any grievances tended to be short lived. We spoke with staff about these comments as we felt it was important for staff to be aware that some patients may not feel confident to discuss peer-to-peer ill feeling, and for staff to recognise opportunities to intervene when required.

During our last visit to Radernie Unit we reviewed care plans, and found on that occasion several lacked evidence of patient participation, regular reviews and would not be considered person-centred. For this visit, we were pleased to find care planning had significantly improved. We were told by staff they had used the Mental Welfare Commission guidance for care plans and that this had provided a framework to practice a person-centred approach to care and treatment. Of the care plans we reviewed, we saw evidence of staff seeking views from patients, a multidisciplinary model as well as regular reviews and updates where required. We saw excellent examples of holistic models of care for patients who by virtue of their early life experiences and challenges in adulthood, required staff to adopt a position of authentic empathy, understanding of trauma and how this has had a lasting lifelong effect on well-being. We were told staff working alongside their psychology colleagues ensured a trauma-informed model of care has now been embedded in the ward.

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

Multidisciplinary team (MDT)

Radernie Unit has a multidisciplinary team model for care and treatment. In the core team there were nurses, medical staff, an occupational therapist, support staff and psychology. Each patient had a social worker who also had an additional mental health officer qualification. For patients who required additional support, referrals were made to physiotherapy, a dietician and speech and language therapy. Patients had their care and progress managed using the enhanced Care Programme Approach (CPA). CPA is a framework used to plan and co-ordinate mental health care and treatment. CPA documentation was detailed and available for each patient we reviewed, with evidence of participation from patients and their relatives. Throughout the care records we reviewed, we were pleased to find a broad range of disciplines and professionals providing specialist input for each patient. The ward-based team told us they were determined to ensure patients were provided with care and treatment that was individualised and considered patients strengths as well as their areas of need.

We were told there had been some progress for those patients who were likely to move from hospital-based care back into their communities. However, we heard that the length of time this has taken remained a source of frustration for everyone, including patients and their relatives. We asked about the specific barriers that prevented patients moving on from hospital and we heard it was typically in relation to finding suitable tenancies and importantly, suitable care and support providers. There continued to be challenges with the allocation of tenancies and packages of care to support individuals to live successfully in their community. For those individuals whose discharge from hospital had been delayed, maintaining their engagement with ongoing rehabilitation had been difficult.

Care records

Information about patient's care and treatment was held in the 'MORSE' electronic record system. We found patient's records easy to navigate. There was a clear focus upon individual patient's mental and physical well-being, with several assessments based upon physical health. Patients in Radernie Unit required continual assessment based upon their level of individual risk, which for a variety of reasons, could not be safely managed in less secure environments. We were pleased to see that risk assessments were reviewed regularly and amended as necessary to ensure patients were provided with opportunities to spend time away from the ward and engage in community or hospital grounds activities. During our last visit to Radernie Unit, we were unable to see evidence of one-to-one engagement between staff and patients. We were pleased to see recordings of patient and staff engagement had improved however, while we could see an improvement, patients told us they would have liked to spend more time with nursing staff.

Recommendation 1:

Managers should ensure patients are provided with time to ensure one-to-one engagement is undertaken at frequency and duration that has been agreed between staff and patients.

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 (Criminal Procedures Act) legislation. All documentation relating to the Mental Health Act and Criminal Procedures Act were available in the patient's electronic files.

The patients we met with during our visit had a good understanding of their detained status where they were subject to detention under either Acts.

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 all in place. We identified two minor issues with prescribed treatment and spoke with medical staff on the day of the visit, who ensured these errors were immediately rectified.

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 continued to operate a locked door, commensurate with the level of risk identified with the patient group. Most patients had unescorted time away from the ward and this was 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 was required in a low secure setting.

We noted that patients had access to independent advocacy. Currently this provision was offered by advocacy staff in-person, with patients given opportunities to meet with advocacy at a time that was convenient for them. Patients could ask for support from advocacy for a range of issues or for support during mental health tribunal hearings. Equally, to ensure patients had access to legal representation, nursing staff supported patients to maintain contact with their legal representative. Mental health officers also provided support and guidance in relation to hearings, whether related to the Mental Health Act or criminal procedures matters.

Sections 281 to 286 of the Mental Health Act 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 be applied. Where specified person restrictions were in place under the Mental Health Act, we found the relevant paperwork, including reasoned opinions were in place.

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 heard from patients they welcomed engagement from members of the multidisciplinary team, particularly occupational therapy. While the ward-based occupational therapist undertook a wide range of formal assessments, they were also available, along with support staff to undertake recreational and therapeutic engagement. For some patients, they enjoyed time spent off the ward, including attending the hospital gym and gardening project. Patients recognised being part of organised activities was important to them, whether this was in small groups or one-to-one work. During our last visit to Radernie Unit, patients often spoke about feeling bored with very little to do to occupy their day. During this recent visit, patients felt there had been an improvement in activity provision. Nursing staff were also keen to explore activity opportunities and had developed an informal questionnaire to ensure patients were offered recreational and therapeutic activities that they were particularly keen to engage in.

There was gym equipment available in the ward, along with access to an outdoor gym in the hospital grounds. An information technology (IT) suite was also available. As with the gyms, this could be accessed under staff supervision.

During our last visit to this ward, we were concerned about patient's access to fizzy drinks, savoury and sweet snacks. Staff had attempted to support patients to reduce their 'snacking', however we were told by the leadership team it had been difficult as there was 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' psychotropic medications administered as patients were regularly presenting with 'agitation'. We had spoken with staff to understand whether there could have been 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. We were pleased to learn during this visit there had been a considerable effort from staff to work with patients to reduce their 'snacking'. Engagement with a dietician had a significant role in supporting patients to consider alternatives to their fizzy drinks and snack options. There was also a recognition that boredom had contributed to patients passing time-consuming large quantities of fizzy drinks, so with an increase in activity engagement, we acknowledged that patients were likely to be more motivated and less inclined to eat snacks, thus improving physical and mental well-being.

The physical environment

Radernie Unit had secure access with additional outdoor space at the rear of the unit. During our last visit, we highlighted several issues in relation to the environment. We were pleased to see there had been some improvements to the communal areas of the ward, with re-decoration of the corridors and the dining room. However, we remained concerned that areas that we had previously identified and made recommendations on had not had any attention. All bedrooms were single with only two having en-suite facilities, otherwise all bathrooms were shared. We were told by patients they found this stressful and believed it to be undignified. We noticed all the shower areas had black mould around the fittings, looked unclean and uninviting. There was an extremely unpleasant odour in all the bathrooms, toilets and corridors leading to them. The shared bathroom was cold, bleak, and appeared unclean. Patients described the toilets, showers, and bathroom as "disgusting" and "would avoid using

them but had to, as no alternative". The toilet/shower rooms were open plan and patients told us there was regularly urine all over the floor that they stepped in when using the shower. They also complained that the non-slip flooring had become so worn, that it was sometimes very slippery and hazardous when wet. Due to patients' feedback and our own observations and concerns, we considered it essential that refurbishment work is undertaken to ensure toilets, shower rooms and the bathroom are safe and fit for purpose.

Recommendation 2:
Managers should as a matter of urgency undertake essential refurbishment and repair work to all toilets, shower rooms and the bathroom.

There was access to outdoor space with a garden for patients to use should they wish. Unfortunately, the garden had not been tended to, looked uncared for, and did not appear as an inviting space to spend time in. We were disappointed to see there had been little evidence of improvements to the garden area. We had hoped the service would have recognised the garden as an investment to encourage patients to spend time outdoors and become involved in creating a relaxing and attractive space to share with patients and staff.

Recommendation 3:
Managers should ensure the outdoor space available for patients has investment to ensure it is welcoming and fit for purpose.

Any other comments

At the time of our last visit to Radernie Unit, we were concerned about several areas that included patient engagement, health promotion and the environment. From this recent visit, we wish to acknowledge the work staff have undertaken to improve patient's experience and also the willingness of staff to promote rehabilitation and recovery for this patient population. We found that the team was motivated and determined to work with their patients using a multidisciplinary, trauma-informed model. We were aware that the team in Radernie Unit had worked collectively to bring about the positive changes and we look forward to hearing and seeing how further progress is made.

Summary of recommendations

Recommendation 1:
Managers should ensure patients are provided with time to ensure one-to-one engagement is undertaken at frequency and duration that has been agreed between staff and patients.

Recommendation 2:
Managers should as a matter of urgency undertake essential refurbishment and repair work to all toilets, shower rooms and the bathroom.

Recommendation 3:
Managers should ensure the outdoor space available for patients has investment to ensure it is welcoming and fit for purpose.

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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