Mental Welfare Commission for Scotland

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

Date of visit: 16 May 2024

Where we visited

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 11 individuals. Individuals in a low secure setting are more likely to have been subject to court proceedings or may not have been able to be cared for safely in adult mental health services.

On the day of our visit, there were 11 individuals receiving care and treatment. We were told there had been several discharges and admissions to the unit. With successful transfers of care back to the community, individuals were given opportunities to continue with their recovery in their own supported tenancies.

When we last visited Radernie Unit, we made three recommendations. Those were in relation to evidencing one-to-one engagement between nursing staff and individuals in this unit; we were also concerned about the environment, specifically bathrooms and toilets, as we were told by individuals the washing facilities were not fit for purpose and had impacted on their ability to undertake personal care. Over the last 12 months we have received regular updates from the ward-based team and senior managers. We had also received an action plan for work to be carried out following our last visit.

Who we met with

We met with five individuals and had the opportunity to review all their care records.

We spoke with the service manager, the senior charge nurse, the lead nurse, and consultant psychiatrist. We also met with advocacy services, nursing staff and received feedback from the adult education team in relation to an education programme which was underway in the unit.

Commission visitors

Anne Buchanan, nursing officer

Susan Tait, nursing officer

Tracey Ferguson, social work officer

What people told us and what we found

During our visit we were keen to hear the views of individuals receiving care and treatment and to meet with staff who were providing input into the ward. Individuals told us “I’ve been here for three years, it’s fantastic”, “I really enjoy attending therapy sessions and groups”, “I feel listened to by the doctors and nurses, I can see things have changed and the ward is so much better”. We were also keen to know whether individuals felt part of their recovery journey, and equal partners in their care and treatment. We were informed individuals were welcomed into the ward-based meetings, their views were actively sought, in particular to recreational and therapeutic activities and with improvements to the environment, the ward felt a welcoming, safe place to be.

We also had an opportunity to speak with advocacy services who supported individuals receiving care in this unit. Advocacy too had felt welcomed in the ward, and individuals were actively encouraged to engage with this service, with the ward-based team recognising individuals required independent support for attending meetings and mental health tribunal hearings.

We also met with a speciality doctor who had recognised a significant improvement with optimising individuals’ physical well-being. This relatively new initiative had identified areas where individuals required a focus upon health inequalities of a population who had been in hospital for a period of time. With a focus upon health and well-being, the ward-based team had observed a considerable improvement in individuals well-being and reducing risks of comorbidities associated with long term mental ill-health.

Care, treatment, support and participation

Treatment was provided through a multidisciplinary team (MDT) model of care. We were told this approach had greatly improved the level of engagement with a focus upon individuals learning new skills through recreation and therapeutic interventions. The ward-based nursing team were supported by medical staff, a regular visiting general practitioner (GP), an occupational therapist (OT), a psychologist, a music psychotherapist, and an adult education team that provided a rolling programme for individuals, to support learning.

A new development of having a third sector service providing support for an individual in the ward had been welcomed by the MDT. This innovative approach had meant an individual could have opportunities to have a re-introduction into their community, thereby increasing their confidence for new experiences and supporting the development of skills for their future in terms of independent living. We were told by individuals who received care and treatment that having input from a range of professionals had allowed them to consider discharge from hospital-based care. This had previously been a rather remote idea however, with daily engagement, those individuals on the ward felt more hopeful.

When we visit wards, we are keen to meet with relatives. Unfortunately, on this recent visit to Radernie Unit we did not have that opportunity. We were informed that the ward-based team were keen to promote participation and engagement with carers and relatives. There was now a designated senior nurse to engage with relatives, with opportunities to provide regular updates and invitations to participate in ward-based meetings and carers support groups. We

advised the team we would be happy to hear the views of relatives should they wish to speak with Commission visitors at a different time.

Care records

Information about individuals' care and treatment was held in the 'Morse', the electronic record system. We found individuals' records easy to navigate. There was a clear focus upon individuals' mental and physical well-being, with several physical health assessments. Individuals in Radernie Unit required rigorous continual assessments 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 those risk assessments were reviewed regularly and amended as necessary to ensure individuals 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 individuals. We were pleased to see recording of individuals and staff engagement had significantly improved. We were able to see links between subjective views of individuals and their sense of where improvements had been identified with their mental well-being. Furthermore, each professional had provided an update on their active engagement and their objective view of the positive impact they had observed. Individuals were regularly invited to consider what was working well, and what would improve their experiences to further promote participation in therapeutic engagement with the care team.

During our review of care records, we brought to the attention of the senior nurses, the use of descriptive language that nursing staff had written in care records. We would expect written communication to be objective, considerate, and professional. On occasion, we found descriptions of an individual's presentation that fell short of the Nursing and Midwifery Council (NMC) standards for record keeping. We saw in continuation records language that could have been considered pejorative, critical, and judgemental. This appeared to have been out of keeping with the work that had been undertaken by senior nursing staff to support individuals who by virtue of their illness, often have considerable communication difficulties.

Recommendation 1:
Managers should ensure all staff who document in individuals' care records are provided with guidance to ensure all documentation is appropriate and professional.

Recommendation 2:
Managers should undertake regular audits of care records to ensure all written communication meets the Nursing and Midwifery Council standards for record keeping.

During our review of care records, we were keen to look at care plans and to see where individuals had participated in their creation. We were pleased to see continued improvement in all aspects of care planning. For example, we found evidence of care plans with specific goals identified by individuals, who would support them to achieve those goals and regular reviews to identify progress. Where goals had been achieved, care plans were updated and amended as necessary. The MDT model of care had lent itself well to ensuring everyone had a bespoke plan of care, engagement was person-centred, and goals were achievable.

During our last visit to Radernie Unit, we were informed by individuals they would benefit from additional recreational and occupational engagement. The ward-based team listened to those views and had developed a recreational and educational programme for individuals. This had been greatly welcomed by individuals who, by virtue of their early childhood experiences were not provided with formal education. Adult education is now embedded in the unit, and further opportunities for personal growth and physical well-being continue to be made available, with regular sessions with allied health professionals including psychology, music psychotherapy, physiotherapy, dietician, and occupational therapy.

The MDT meets weekly to discuss each individual's progress; for some individuals attending their weekly meeting may be difficult. Nevertheless, for those individuals, their views were sought, documented, and discussed with all professionals prior to the meeting. The team recorded detailed discussions of every meeting in the electronic record system. Where an action had been agreed, those were assigned to a specific member of the team with a progress report provided for the next meeting. We could clearly identify who had attended the meetings, actions and outcomes to improve individuals' care, treatment and progress.

Use of mental health and incapacity legislation

On the day of our visit all individuals were subject to either the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) or Criminal Procedure (Scotland) Act 1995 (Criminal Procedure Act) legislation. All documentation relating to the Mental Health Act and Criminal Procedure Act was available in the electronic files.

The individuals we met with during our visit had a good understanding of their detained status, where they were subject to detention under the 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 and corresponded with the prescribed medication.

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.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act (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 each section 47 certificate had been completed correctly and had a comprehensive treatment plan accompanying it.

Rights and restrictions

Radernie Unit continued to operate a locked door, commensurate with the level of risk identified for individuals in that care setting. Most individuals had unescorted time away from the ward and this was reviewed regularly by the MDT. Individuals 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 all individuals had access to independent advocacy. This provision was offered by advocacy staff on an in-person basis, with individuals provided with opportunities to meet with advocacy at a time that was convenient for them. Individuals could ask for support from advocacy for a range of issues or for support during mental health tribunal hearings. Equally, to ensure individuals had access to legal representation, nursing staff supported them to maintain contact with their legal advisor. 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 is applied. Where specified person restrictions were in place under the Mental Health Act, we found all authorising paperwork was in place.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 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. Health boards have a responsibility for promoting advance statements. We found evidence of advance statements' available for each individual who had been supported to write one. We recognised for individuals who receive care and treatment in a low secure setting it is important for them to document their views about the treatment they wish to receive. There was evidence of discussions with individuals to ensure any decisions were made were fully understood by individuals and the care team.

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.

Activity and occupation

During our conversations with individuals and the ward-based team there was a recognition that the improvements in activity provision for Radernie Unit had made a positive impact on mental health and physical well-being for all individuals. Activities were individualised and engagement had improved. With the addition of adult education, individuals told us they had felt learning had made a difference to their self-esteem and were keen to explore more avenues for learning and developing numeracy skills. There was a good balance between recreation and occupation activities, with a focus upon physical well-being, which was clear as the MDT, had taken a holistic approach to care and treatment.

For individuals, they told us they felt their relationships with staff had improved, and their views about activities had been listened too and sharing of ideas had been welcomed. There were opportunities for individuals to engage in activities outside of the ward, which had supported their continuing rehabilitation while also making local connections with their communities.

The physical environment

Radernie Unit is based in the grounds of Stratheden Hospital; it 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, new flooring, and with new artwork the ward appeared brighter and a more welcoming environment.

While bathrooms had some remedial work undertaken, it was clear significant improvements are still required. We were also aware during our visit, the garden required attention to make it a useable space, particularly during the warmer weather. We were told by the senior management team, funding for improvements had been agreed. We look forward to seeing these improvements to the ward during our future visits.

Any other comments

We wish to acknowledge the continued improvements evident throughout our observations and conversations with individuals receiving care and treatment in Radernie Unit. We were again pleased to see the commitment from all staff who provided input to ensure each individual's rehabilitation experience was progressive and bespoke in approach.

The model of care was holistic, this ethos had taken determination from individual staff while also acknowledging progress was a shared experience and, for individuals their voices had been heard. This shared experience had undoubtedly been the catalyst for the improvements we were able to reflect upon during this visit. We look forward to hearing from the team throughout the next 12 months and of the improvements to the ward environment too.

Summary of recommendations

Recommendation 1:
Managers should ensure all staff who document in individuals' care records are provided with guidance to ensure all documentation is appropriate and professional.

Recommendation 2:
Managers should undertake regular audits of care records to ensure all written communication meets the Nursing and Midwifery Council standards for record keeping.

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 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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