Mental Welfare Commission for Scotland

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

Date of visit: 8 May 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

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 and may have been transferred to this unit from a facility with higher levels of security on the forensic pathway. For some individuals, the admission to the unit may have been due to their presenting needs and increased risks that could not be met safely in an adult mental health ward.

On the day of our visit, there were nine people on the ward, with two individuals residing at Chestnut Lodge, a separate service based in the grounds of Stratheden Hospital, although support is provided by Radernie staff. Managers told us that the Lodge had not been used for a significant period, however, was currently supporting two individuals to prepare, develop and test their skills before moving to community living. While the Lodge was not staffed, Radernie staff were identified on each shift to provide support to people in the Lodge and carry out necessary tasks.

We last visited this service in May 2024 on an announced visit and made two recommendations about nursing recordings and documentation. The response we received from the service was provided in a detailed action plan, which outlined how the service planned to meet the recommendations.

On the day of this visit, we wanted to follow up on the previous recommendations and look to see how the service was progressing with any delayed discharges.

We were pleased to hear that there had been several discharges since our last visit with discharge planning for some other individuals progressing well. We were also told that there were individuals who were currently in medium secure units who had been identified as requiring a lower level of security, therefore progressing discharges in a timely and planned manner provided the opportunity for transfers to occur into the unit.

Who we met with

We met with five individuals and reviewed the care of four people. We did not meet or speak with any relatives.

We spoke with the senior charge nurse (SCN), the lead nurse, the interim clinical nurse manager, other members of nursing staff, the occupational therapist (OT), the psychologist and the speciality doctor.

Commission visitors

Tracey Ferguson, social work officer
Anne Buchanan, nursing officer
Graham Morgan, engagement and participation 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 were all at different stages of their recovery journey. Of the 11 individuals in the unit, there were four individuals who had been in the ward for less than a year, with five individuals who had been in the unit for over three years. The longest inpatient stay was one individual who had been in the unit for being approximately seven years.

While all individuals were subject to rigorous risk management monitoring, time off the unit for some was at the approval of Scottish ministers.

We received mixed feedback from individuals. One individual told us that they were "treated well in the ward" although they were not interested in activities that were on offer. Another described the input from psychology as "good" and that "staff were fine, and the ward manager was great".

We spoke to a few individuals who told us that they would like more time off the ward, that they "liked doing music but would like to do other stuff too". One individual told us that they didn't want to be in hospital, that they would like to smoke in back garden and felt unsure about the future. A few people we spoke with felt restricted and described being in the ward as a 'lack of freedom', while another told us that there were happy with their treatment, that they felt involved and were happy with the time spent off the ward.

We heard about input from the Scottish Action for Mental Health (SAMH) service, with a few people describing their input as "good". One person told us that they felt involved with changes in the ward, and how it was good that staff asked individuals about changes needed.

A few people told us about the scheduled activities available, including a garden group, psychology groups, and walking groups.

We heard from some individuals who told us that they felt safe in the ward and that they liked to have their own room, as this provided them with privacy, which they were able to retreat to if the unit became too noisy.

Another person we spoke with told us that they were not happy at being in hospital, were unhappy with their treatment and preferred to do no activities but felt that the staff had a "good attitude".

One individual described their time on the unit, telling 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 gained the sense from speaking to individuals that they knew about their rights and their current legal status and how to access support from a solicitor and from advocacy.

Care, treatment, support, and participation

The care plans that were in place were holistic, detailed and covered a wide range of needs. They were goal orientated, detailing the intervention to meet the goal. The care plans were regularly reviewed and there were detailed recordings of the reviews.

Where it had been identified that a new care plan was required, we saw that this had been developed and put in place. From reviewing the care plans, it was positive to see the individuals 'voice' being incorporated throughout the care planning stage, even where the individual disagreed with some aspects of the planning.

Everyone was subject to enhanced care programme approach (CPA), with meetings held every three months. CPA is a framework used to plan and co-ordinate mental health care and treatment, with a particular focus on planning the provision of care and treatment by involvement of a range of different people and by keeping the individual and their recovery at the centre.

The MDT model of care lent itself well to ensuring everyone had a bespoke plan of care, that engagement was person-centred, goals were achievable, and this was fully incorporated into the CPA meeting minutes.

For the two individuals who were living at Chestnut Lodge, the service had developed a new care plan for this purpose, and while the plans were detailed, we felt these needed to be more focussed on the rehabilitation aspects and purpose of being at Chestnut Lodge. We found from reviewing the care records that the two individuals appeared to attend the unit frequently for some care aspects, such as self-medication and some one-to-one meetings with staff. We spoke to nursing staff who told us that they tended to still spend time on the ward, as it was sometimes difficult to get used to the different setting and being around less people.

Care records

Information about individuals' care and treatment was held in the electronic system 'Morse'; we found the records easy to navigate.

There was a clear focus upon individual's mental and physical well-being, with several physical health assessments. Those in Radernie Unit required rigorous, continual assessments based upon their level of individual risks, 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. The SCN told us that the risk management plans were reviewed daily, and we found that this defined in the nurses' daily recordings. Furthermore, each professional had provided an update on their active engagement and their objective view of the positive impact they had observed.

We found that nursing staff were carrying out regular one-to-one meetings with individuals, where their views were always being sought and we found detailed entries from the one-to-one's that were happening when individuals were out on activities. We found the entries by the OT and physiotherapist to be detailed and meaningful and sensed that individuals had the opportunity to build on relationships that allowed them to open up while out on the walking trips.

On our last visit we found some nursing entries on MORSE that were not in line with the Nursing and Midwifery (NMC) standards on record keeping. We were pleased to find no entries of such nature on this visit and to hear about the actions put in place by the leadership team to enhance the recordings and ensure they comply with professionals standards.

Multidisciplinary team (MDT)

There is a wide range of professionals that provided input to individual's care in the unit. The multi-disciplinary team (MDT) consists of a locum psychiatrist, a speciality doctor, a clinical psychologist, an OT, a music therapist and nursing staff.

The MDT met weekly and reviewed every individual's progress on a fortnightly basis. We were told that this meeting was attended by all the professionals, including social work or mental health officers (MHOs), when necessary. Where a person did not wish to attend, individuals' 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, and the actions and outcomes to improve individuals' care.

We were told that there was no longer GP provision into the unit and other members of the MDT we spoke with shared concerns about this. Managers told us the service level agreement that the unit had with the local GP practice ended in February 2025. Managers told us that staff presented information to them about how effective and valuable the GP input to the unit had been, which had resulted in a full service wide review. We will request an update from managers about the outcome of this review.

Although there was no GP input to the ward, we still felt that there was a good level of input regarding individuals' physical healthcare and everyone had a completed passport for health.

Everyone had a planned enhanced CPA date scheduled from their last meeting and from reviewing the records, we were able to see the evidence that the MDT were all working collaboratively to achieve the best outcomes for individuals, whilst also managing risk effectively.

We were aware that one individual's discharge had been delayed, however, we were satisfied that there continued to be ongoing MDT discussion when considering the next steps for this person.

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 and easy to locate.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, 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, apart from one. We brought this to the managers attention in order to address.

Any individual 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 person had nominated a named person, we found copies of this in their file, and it was clearly recorded on other documents as to whom the named person was.

For those people that were subject to the Adults with Incapacity (Scotland) Act, 2000 (AWI Act) we found the appropriate documentation in place and this was easy to locate.

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 each section 47 certificate had been completed correctly and had a comprehensive treatment plan accompanying it.

We had been informed that there was one individual's monies that were being managed by hospital managers under Part 4 of the AWI Act, however on reviewing the care notes there was no certificate in place. We brought this to the attention of the speciality doctor and SCN, who informed us that the individual's monies were no

longer being managed via this legislation. We discussed this further with them and requested that the documents in the care records reflect this information.

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. Some 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 although this is a requirement of a low secure setting. We were aware that some individuals time off the ward was at the approval of Scottish Ministers and that initially, individuals' suspension plans had to be approved, with progress monitored and reported back.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital. Where an individual 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, apart from for one person. We discussed this further with the SCN and at the end of day meeting with senior managers. Documentation recorded that the individual had been made specified for correspondence, however there was no paperwork in place to support this, nor had the Commission received notification of this. We requested the RMO to review this and submit the necessary paperwork to the Commission following the review.

We had a further discussion with managers about the restrictions that were in place for the two individuals who were living at Chestnut Lodge. One individual was soon to be discharged, and our view was that where someone was due to be discharged, being subject to such restrictions was not compatible with this. We believe that the MDT need to consider how to lessen such restrictions using a planned and risk management framework as part of individual discharge planning.

Individuals had access to independent advocacy where they wished to and where individual's requested support at meetings and mental health tribunals, advocacy was available. Some individuals also told us about their access to legal representation and how this supported them with their rights. We found that individuals had regular contact with their MHOs who also continued to inform them of their rights. We did not speak with advocacy before the visit and plan to follow up on this post-visit.

When we are reviewing individuals' files, we look 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. 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 and where a person did not wish to write one, this was recorded in their care records. We were pleased to see that there continued to be ongoing discussions with individuals about advance statements and this was referenced in the CPA meetings.

The Commission has developed *Rights in Mind.* 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

The unit offered a 'mind and move' programme that provided individuals with physical exercise that was designed to empower, educate and improve physical and psychological outcomes for individuals. These sessions were led by the exercise instructor and were offered in a one-to-one session or small groups.

We were told that a physical activity readiness questionnaire was completed prior to any session commencing as this enabled the programme to be tailored towards individual needs. The unit also had access to physiotherapy and was allocated dedicated time for small gym group sessions in the main fitness hub in the hospital grounds, the Ceres centre.

There was also exercise equipment in the unit, and we were told that this was less used now as individuals preferred to go off the unit, however, the equipment still provided the opportunity for individuals to work out at times out that suited their schedules and for individuals who were not able to spend time off the unit. The hospital grounds also had an outdoor gym, with low level equipment that could be used by anyone.

The OT, along with the exercise coordinator offered local walking groups and we heard from individuals about these walks and how this benefitted them. We heard that this helped to build their confidence, create links to the community and support them work towards discharge. 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.

From speaking to individuals, they were able to tell us about their activity schedule and the positive impact this had on their outcomes and lifestyle. For a few others they were able to tell us of the activities on offer, but did not always want to engage.

The psychologist told us about two therapy groups that were in place and one of those was about preparing for discharge. Individuals would be invited to this closed

group. It was positive to hear about this group, as we recognise that preparing for discharge can be a complex and stressful time for individuals, especially for those who had been in hospital for a significant amount of time.

Staff and individuals told us about the input from SAMH, a third sector organisation who have been commissioned to provide support to individuals on and off the ward. We spoke with the SAMH workers to gain a sense as to how they were contributing to individuals' recovery and how they worked as part of the MDT. We were told that there had been ongoing discussions as to how SAMH recordings could be integrated to the unit's record keeping systems. We heard that the plan was for SAMH to electronically document their input for the care records, which would then be uploaded. Some of the activities that SAMH supported individuals with included time outside in the garden, or trips to the local community. For some, they enjoyed playing board games, jigsaws and playing pool in the unit.

From reviewing the care records we were able to see the number of activities in place and of the outcome of what was achieved, positively promoting mental health and physical well-being for all individuals. We found that activities were individualised and tailored to meet specific outcomes and where activities were offered and not accepted, we saw this recorded in the care records.

We were told that the unit was waiting on a new lead educator to start as the previous one had left. We will request an update from managers about this.

The ward held community meetings where issues were discussed and the meeting provided individuals with the opportunity to have a say on specific issues. Some individuals we spoke with told us that the idea was good, but a few others told us that the meetings were not helpful.

The SCN told us about a more recent development 'coffee with a cop' where the local police officer(s) would attend the ward and invite individuals to come and meet with them to discuss any issues about the local community. These meetings were held two monthly and the SCN told us that the people in the unit responded well to the visits.

The physical environment

Radernie Unit is based in the grounds of Stratheden Hospital; it has secure access and egress, with additional outdoor garden space at the back of the unit. We were told of ongoing development works in the garden area and that a garden project had been set up, with individuals being part of this and bringing ideas about how to improve the area.

The unit appeared bright and the environment was welcoming. The ward has all single bedrooms, with built in wardrobes and some had en-suite facilities. There

were other shower facilities located in the ward and the SCN told us about the ongoing improvement works that we had noted in our previous reports. It was good to see that some of the level access shower rooms had been refurbished, providing a clean environment. Some of the other shower rooms had not been refurbished and we were pleased to note that these remained clean and mould-free, as had been reported on previous visits. We did note an odour in the corridor to the shared shower rooms and were told that this was likely from the drains. Managers told us that there had been an issue with drainage on the Stratheden site for some time, however, agreed to look into this further, given the strong odour in the corridor. The door to the shower rooms was off the unit, therefore there was no odour throughout the unit, only in this specific corridor.

The unit had a laundry room with washing machine and dryer, and there was a separate room that was used for activities. There was another room where musical instruments were stored, and we were told this room was used by individuals and the music therapist. There was a computer room and a self-catering kitchen. Access to all these rooms was outside of the main unit and staff supervision was required when access to these rooms was needed.

There was a lounge with a television, pool table and ample seating in the main unit. There was also a quiet room available.

We heard of the changes in the environment over the past few years and the staff we spoke to had welcomed these changes, feeling that the improvements had benefitted everyone. We had the impression that the service was making best use of the facilities in the unit and continued considering and discussing how to make further changes in order to make the unit a more homely and comfortable environment.

We visited Chestnut Lodge which could accommodate up to three individuals. Each had their own bedroom space with communal kitchen and living area. There was also a small quiet room where meetings took place. We were told that as part of individual's care plan, they were responsible for keeping the environment clean and tidy. There was a weekly domestic cleaning service to the property given this property was still the Hospital's responsibility.

We were told that when individuals left the property, they had a responsibility to call the unit as per health and safety guidelines. We are keen to hear more about the use of this facility and will continue to link in with managers about this.

Service response to recommendations

The Commission made no recommendations from this visit.

We would like to receive information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. We will follow up with the service to obtain this information.

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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