Mental Welfare Commission for Scotland

Report on announced visit to: Stratheden Hospital Hollyview Ward, Springfield, Cupar, Fife, KY15 5RR

Date of visit: 2 October 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

Hollyview Ward is a mixed-sex, intensive psychiatric care unit (IPCU) based in the grounds of Stratheden Hospital. The IPCU is an eight-bedded, locked unit that provides intensive treatment and interventions to individuals that present with an increased clinical risk and are likely to require a higher level of observation.

The IPCU admits individuals known to the general adult psychiatric (GAP) services and forensic psychiatric services.

Individuals could also be admitted to this ward via the courts, due to criminal offending behaviour, transferred from prison due to mental ill health or following a referral from the community teams.

On the day of our visit, there were eight males in the ward.

We last visited this service in September 2024 on an announced visit and made a recommendation about activity provision.

On the day of this visit, we wanted to follow up on the previous recommendation and meet with people to hear about their experience of being in this ward.

Who we met with

We met with four people and reviewed the care notes of those four individuals. On the day of the visit, we spoke with the lead nurse, senior charge nurse (SCN), ward-based nursing staff, the consultant psychiatrist and head of nursing.

Commission visitors

Tracey Ferguson, social work officer

Susan Hynes, nursing officer

What people told us and what we found

Feedback from individuals about staff was positive, where individuals described staff as “good”, “nice” and “approachable”. One individual told us that they “loved the staff”. A few individuals were able to tell us about their involvement in their care and treatment and told us how they felt listened to as they met with the doctor regularly to discuss their care and treatment.

People told us about their time off the ward and of the activities that were available. One individual told us about their plans for the next stage of their recovery. Individuals said that having their own space was important to them. We got the impression from speaking to people that they knew about their rights and where individuals were acutely unwell, we were reassured that they had support to enable them to access information about their rights.

Staff we spoke with told us that the team was good and supportive, however there were times where activities had to be restricted due to the complexity of some individuals’ clinical presentation and the need to prioritise nursing tasks. The SCN told us that up until recently, they had three people on seclusion in the ward, where significantly higher staffing levels were required to manage risks and ensure individuals’ needs were being met.

On the day of our visit, we saw positive interactions between individuals and staff, particularly where the person was experiencing levels of distress due to the acute phase of illness. We also got the sense that the staff knew the individuals well and knew how to support them in their recovery journey.

The SCN told us about continued proactive efforts to recruit staff to vacancies, and it was positive to hear that they had recently recruited to some vacant posts through the new graduate recruitment. The SCN and lead nurse told us that the number of staff had increased in the IPCU by one whole time equivalent (WTE) since our last visit and that the ward was currently recruiting for a Band 5 nurse.

The lead nurse told us that the increase was positive however, the current level of staffing did not meet the safe staffing levels that the ward required to have under the obligations of the Health and Care (Staffing) (Scotland) Act 2019 and that the health board were undertaking work with Healthcare Improvement Scotland to address this.

Care, treatment, support, and participation

From reviewing the care records, we found detailed daily entries by nursing and medical staff that were meaningful, relevant, and provided an update on the progress of the individual’s care and treatment. We saw that nursing and medical staff were continuing to gather people’s views about their care and treatment and recorded these in their care records. This was also evident in the regular one-to-one discussions that people had with nursing staff.

We found that most care plans were detailed, holistic and strengths-based, with identified interventions to support the person to meet their goals. There were regular reviews taking place that included individual participation, where possible.

Although no one in the ward was subject to seclusion on the day of our visit, we reviewed the care of individuals who had recently been subject to these restrictions. The seclusion care plans were detailed and had been reviewed daily by nursing and medical staff. We did find that there was one individual's care plan where there were some gaps in the daily review on the electronic system however, we were told that the staff continued to also keep a paper-based file where there was evidence of daily reviews. The lead nurse agreed to take this forward to ensure both systems contained accurate information.

Detailed risk assessments and risk management plans were in place, and we saw that those documents had been regularly reviewed and updated. It was positive to see that relatives had input to this document. We found two risk management plans where the information was not as detailed as the others; we provided examples of these to the SCN and requested that these documents to be reviewed.

We were told that the SCN provided a monthly care assurance report to managers and that the charge nurses were involved in the audit process. This enabled the senior leadership team to identify any specific issues and address any performance management concerns, as well as identify good practice, across the team.

Care records
Individuals' care records were held on the electronic recording system, MORSE. We heard how staff across services were highlighting areas that required to be improved, in order to support them in their role, and that these continued to be taken forward in the wider system. We look forward to hearing more about the improvements of this system for staff.

We found the system easy to navigate and all documents were easily accessible.

Multidisciplinary team (MDT)
The consultant psychiatrist that covered the unit had responsibility in determining admissions to the IPCU. They reviewed everyone's care and treatment on the ward and identified whether the person had forensic needs or not.

We were told that MDT meetings continued to take place weekly, and the meeting was attended by the consultant psychiatrist and nursing staff. We also saw regular attendance by mental health officers (MHOs) and social workers. The ward had regular pharmacy input and the pharmacist attended some of the MDT meetings. We continued to hear concerns from the team about there not being a full complement of MDT professionals attached to the ward and providing input into peoples' care and recovery. Individuals admitted to the IPCU were at their most vulnerable, often

acutely mentally unwell, requiring input from a robust MDT to support and aid their recovery, however this was not available.

We were told that access to psychology services was not available for individuals in the IPCU and that only individuals who were being looked after by forensic mental health services were able to access this service. We were advised that these individuals would continue to have access to the forensic psychologist while in the IPCU for continuity of care, however there was no equitable access to psychology for individuals who did not have forensic needs.

When we reviewed one individual's care, we were able to see how this individual would have benefitted from psychology input. We continue to be concerned that individuals in the IPCU do not have an equitable access to psychological services.

Recommendation 1:
Managers must ensure equitable access to psychological services for all individuals admitted to the IPCU.

Senior managers had told us that there had been difficulty recruiting to occupational therapy posts across the health board. The ward did not have a dedicated occupational therapist (OT) and the lead nurse told us that there had been discussions about receiving some input from an OT who was based in another service. However, discussions had just taken place, and nothing had been arranged and agreed at the time of our visit.

Recommendation 2:
Managers must ensure equitable access to occupational therapy for all individuals admitted to the IPCU.

For individuals who required additional support from other allied health professionals (AHPs), we were told that referrals were made to specific services, such as physiotherapy, dietician or speech and language therapy.

The electronic MDT meeting record provided a detailed overview and update of the individual's care and treatment and recorded who attended this meeting, along with outcomes and actions. These records were detailed and included a comprehensive nursing summary. We found this electronic recording format to be robust and it covered all necessary aspects of a person's care and treatment, including ongoing monitoring of physical healthcare.

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 (the Mental Health Act) or the Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure Act). All documentation relating to this legislation was available in the electronic files.

Individuals we met with during our visit had a good understanding of their detained status.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained people, 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 where high dose monitoring was required, we found the paperwork to be in order.

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 an individual had nominated a named person, we found a copy of this in the person's file

There was one individual who was subject to a welfare guardianship order under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act). We found a copy of the order in the paper file but not in the electronic record. We requested the consultant psychiatrist to review the person's capacity to determine if an AWI Act section 47 treatment certificate was needed to treat their physical healthcare.

All of the above certificates were easy to locate and kept together with each individual's medication prescription kardex.

Rights and restrictions

The design of this IPCU meets the national standards for intensive care locked wards that support people who have risks that require a low level of security.

On the day of our visit, there was no one being nursed on continuous intervention or seclusion. The SCN told us that where an individual was on continuous interventions, there was a review process in place. From reviewing the care records, we found where individuals had been on an enhanced level of observation, this had been reviewed and discussed at the MDT meeting and the decision recorded.

We were also told that individuals' time out of the ward was reviewed at each MDT meeting and recorded in their care plan. We found this information when reviewing the care records. The ward had a seclusion policy in place, and we found that where individuals had been subject to seclusion that staff made reference to this policy throughout the care records.

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 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. Five people in the ward had been made a specified person and where these restrictions were in place, we found all authorising paperwork, including reasoned opinions which

detailed the need for the restriction, in the electronic file. We also found care planning in place to evidence the ongoing review and necessity of such restrictions.

We found from reviewing files that the ward-based nursing staff, MHOs and advocates continued to support people with their rights, and we saw where information had been provided to individuals which was accessible for them. The ward displayed QR codes on some walls in the quieter rooms in the ward and individuals told us that the QR codes helped with information and accessibility.

When we review care records, we look for copies of advance statements. The term advance statement refers to written statements made under s275 and s276 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. No one in the ward had an advance statement in place. We were pleased to see the ward had taken a positive approach to supporting individuals to consider advance statements, particularly when people became more well and were able to make one.

The Commission has developed *Rights in Mind.*[1] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

We wanted to find out how the ward was implementing our recommendation from last year about activity provision.

The ward did not have a dedicated activity therapist in place. Activity provision was being delivered by the ward-based staff; however, this was dependant on clinical activity. We had concerns about the ongoing lack of dedicated activity provision the lack of progress since we had made a recommendation around this from our visits in 2023 and 2024.

The lead nurse informed us that a 'situation, background, assessment and recommendation' (SBAR) report had been completed and submitted to senior managers to seek approval for funding a post, but there had been no approval as yet. We were told that there were ongoing discussions with the AHP manager about the repurposing of posts across the health board to contribute and deliver therapeutic activity provision across wards. We have also found on other local visits across Fife that the availability of therapeutic activity provision is lacking due no dedicated provision of OT, physiotherapy and activity co-ordinators in place. We were told that there had been some discussions about Hollyview Ward receiving some time from the forensic OT, however this had not commenced.

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

Some of the individuals that we spoke with, were able to tell us about their activities on and off the ward, and how these activities were important to them. On the day of the visit, we saw people playing snooker in the activity room and playing games.

While we noted there to be a level of activity provision in place, our expectation would be that there should be ongoing daily therapeutic activity as part of a person's care and treatment plan that contributed to their recovery. We gained the sense that staff were committed and valued the importance of therapeutic activities, however with the absence of dedicated provision from other specialists, in many cases, individuals' recovery relied mostly on use of psychotropic medication.

As the previous recommendation had not been met, we will once again repeat this recommendation.

Recommendation 3:
Managers must ensure that a dedicated activity therapist post is put in place to provide daily therapeutic activities to individuals in the IPCU.

The physical environment

This ward was opened in 2016 and was purpose built with modern facilities that included two enclosed outdoor garden areas. The ward was bright and spacious and provided individuals with the opportunity to socialise or have space to relax away from others should they wish.

There were several communal areas, various sitting areas, a kitchen, an IT suite and a fully equipped gym. All bedrooms had ensuite shower facilities, and we were told that all the bedroom furniture had been replaced as part of ligature reduction works. The ward had bespoke furniture in communal areas, and we heard about plans to look at sound proofing in the ward.

Summary of recommendations

Recommendation 1:
Managers must ensure equitable access to psychological services for all individuals admitted to the IPCU.

Recommendation 2:
Managers must ensure equitable access to occupational therapy for all individuals admitted to the IPCU.

Recommendation 3:
Managers must ensure that a dedicated activity therapist post is put in place to provide daily therapeutic activities to individuals in the IPCU.

Service response to recommendations

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

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

When we visit:

- We find out whether an individual's care, treatment, and support are in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia, and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice, and guidance to people we meet with.

Where we visit a group of people in a hospital, care home, or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports, and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line, and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk