Mental Welfare Commission for Scotland

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

Date of visit: 8 August 2018

Where we visited

Radernie Ward is a low-secure forensic ward based within the grounds of Stratheden Hospital in Fife. It is a 10-bedded unit and is an all-male facility. The ward has been refurbished in the last number of years from an existing building and the environment has been specifically adapted to provide conditions of low security. The ward attachment area is the whole of Fife. There were no patients admitted from out with the NHS Fife catchment area on the day of our visit.

Patients within a low-secure setting will 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 July 2015 and made one recommendation relating to the use of medication.

We also visited in 2016 as part of our themed visit to all medium and low secure wards across the country. A report was published in August 2017 which detailed our findings and can be found at:

https://www.mwcscot.org.uk/media/385624/medium_and_low_secure_forensic_wards.pdf

On the day of this visit we wanted to follow up on the previous recommendation and also look at some of the issues identified in our themed visit report. These include physical health care and health promotion, use of restrictive practices, activities and discharge planning.

Who we met with

We met with and/or reviewed the care and treatment of six patients and also spoke to three carers/relatives. On the day of our visit the ward was full, with all 10 beds being occupied. In general, patients were positive about the care and treatment they received. Relatives raised the issue of communication with us and we will address this in more detail later on in the report.

We spoke with the senior charge nurse, other members of the nursing team, the occupational therapist, and the consultant psychiatrist who covers the ward. The senior charge nurse updated us on plans for a small step down facility which is being developed. This will be on the Stratheden Hospital site and aims to provide more independent living for individuals near to discharge.

Commission visitors

Paula John, Social Work Officer

Claire Lamza, Nursing Officer

What people told us and what we found?

Care, treatment, support and participation

We spoke to six patients and most stated that their care and treatment was of a good standard. Some, however, were unhappy in relation to certain aspects of care, such as time spent off the ward and taking medication. We were able to offer advice in these areas, but primarily they were issues for the clinical team.

Patients felt that staff were approachable and able to make time for them if they needed to discuss any aspects of their time on the ward. There were some exceptions to this where a minority of staff were mentioned by patients. We brought this to the attention of the senior charge nurse on the day. All patients commented that staff seemed busy and appeared to be stretched at times.

Patients added that they were involved in aspects of their care planning, and those that we interviewed were able to narrate aspects of future planning and decision making to us. They seemed to be clear on plans for their future and what they needed to realise to achieve moving on from hospital. We noted evidence of patient participation at meetings in the case records and these were well documented. We noted both multi-professional team meetings taking place and Care Programme Approach (CPA) meetings. The latter were well minuted and had adjoining care management plans and risk assessments. The multi-professional meeting includes nursing, psychiatry, occupational therapy, and social work services. We were advised that there had been a gap in psychology provision, but this area was now resolved and there is regular input into the ward.

In relation to case recording, Radernie Ward now had an electronic system which we were able to access. Overall, this contained good content with care plans, risk assessments and management plans, case notes and minutes of meetings. There was also a calendar for each individual, which highlighted ongoing recreational and therapeutic activities. There was evidence of clear goal setting, with regular reviews taking place which identified progress. Staff reported that they found the electronic system far more effective and that its introduction had been a positive addition to the running of the ward.

We also found evidence of the use of rating scales and assessments which assisted with noting improvements in mental health and overall recovery.

We noted that physical health care was included on the care plans and Passport to Health documentation was in place. We were told, however, that there was no visiting GP and that annual physical health checks were undertaken by staff, but any additional needs required an on-call doctor. This service was based at a general hospital site some distance away and this, we were told, sometimes led to delays. Given that the length of stay for some patients in low security can be lengthy, and that physical health care features in the current Mental Health Strategy, we would suggest

that this service is reviewed. We are also aware that other wards on the Stratheden hospital site have a visiting GP service.

The carers that we spoke to advised us that they felt they had poor communication with the ward team and this had been a consistent theme over a number of months. They had limited knowledge of the function of the ward and felt this had not been explained to them. They said they were not consulted by clinical staff when they were in the role of named person, under the Mental Health (Care and Treatment) (Scotland) Act 2003, and no communication took place in relation to general care and treatment issues. Family and carer participation did not appear to be as well documented as that of patients. This appeared to be in contrast to our last visit in 2016 when we were made aware of a carers support group that took place within the family room. This work had been led by a member of the staff team who is no longer on the ward.

These issues were raised with the senior charge nurse on the day and he was able to resolve some of the individual concerns raised. Given the nature of a low-secure ward, the requirement for restriction and planning for visits should be clearly explained to family members, friends, and carers.

Recommendation 1:

Managers should review their carers' policy particularly in relation to communication, provision of information and support.

Recommendation 2:

Managers should review the current provision of physical health care options for patients.

Use of mental health and incapacity legislation

We were able to locate the appropriate mental health paperwork which was contained in hard copy case files on the ward. These were completed well and easy to locate. All patients within Radernie Ward were subject to legislation and there was evidence that they were informed of their rights in relation to advocacy and legal representation.

There were no issues with the paperwork. It was up to date, signed, and appropriately authorised medication. Where required, certificates authorising treatment where individuals were thought not to have capacity were also in place.

Rights and restrictions

All patients within Radernie were subject to some form of legislation and restrictions in relation to time off the ward. These restrictions are individually assessed by the clinical team. All patients had a care plan relating to this and there was also evidence that named person status and advance statements had been discussed with them.

This information was clearly recorded in the notes. Through discussion it was clear that both patients and relatives had a good understanding of both of these and stated that they were helpful. The advance statement paperwork was also clearly linked to the CPA process which aided participation.

We noted that patients were subject to specified persons regulations under the Mental Health (Care and Treatment) (Scotland) Act 2003. These gave ward staff the authority to restrict specific items, such as phones, or limit correspondence. A rationale for this must be clearly documented and details of a review discussed with patients. We were able to identify both reasoned opinions and details of review within the notes.

Activity and occupation

There were a range of activities taking place both on and off the ward with evidence of ongoing engagement with an occupational therapist, who we managed to speak to on the day. He was involved with all patients who were keen to take part in activities and contributed to the multi-disciplinary approach of the team. Activities both recreational and therapeutic were available, for example music therapy. There was also psychology input as well as some low-intensity therapies provided by nursing staff. Horticulture and volunteer placements off the hospital site were also in evidence.

Where possible, patients were also encouraged to maintain standards of daily living by doing their own shopping, cooking, and managing their own laundry. Again this was care-planned for on an individual basis.

As identified earlier, activities were identified in the care plan and each electronic record had a weekly planner so that activities can be viewed. This also functioned as an audit tool to discern how many patients are participating.

There was mixed feedback from patients in relation to activities with some stating there was not enough to do, and others commenting that they were actively participating. This seemed to be variable depending on each patient's individual progress in relation to discharge.

The physical environment

Radernie Ward has been specifically adapted in the last number of years to function as a low secure unit. It is a spacious ward which includes a dining area, living space, activity room, and a therapeutic kitchen. There are also gym facilities and office spaces separated from the patient areas. All patients had their own rooms, but only two had en-suite facilities. There were sufficient bathrooms and shower areas, which patients shared. The environment was clean and well maintained and attempts had been made to make the communal parts of the ward more comfortable. The ward is accessed via a reception area where all visitors are received. A large family room is available for patients and their relatives.

We were told that rooms were not locked during the day, and patients are encouraged to come out of their rooms and become involved in the day-to-day activities on the ward.

We noted that one room had damp on the ceiling, and the senior charge nurse would address this with estate management.

A large secure garden area was available and this had been maintained to a good standard. There is no smoking on the ward or garden area. There were no concerns expressed by patients in relation to the physical environment.

Summary of recommendations

1. Managers should review their carers policy particularly in relation to communication, provision of information and support.

2. Managers should review the current provision of physical health care options for patients.

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

Alison Thomson, 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 MWC 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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