Mental Welfare Commission for Scotland

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

Date of visit: 16 June 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

Lomond Ward is a 29-bedded, mixed-sex, adult acute admission ward that provides care and treatment for individuals who reside in the Fife area. On the day of our visit, there were 19 people on the ward.

We last visited this service in March 2024 on an unannounced visit and made recommendations about care planning, therapeutic engagement and bed capacity. The response we received from the service was outlined in a detailed action plan.

On the day of this visit, we wanted to follow up on the previous recommendations and look at how the service had actioned these. The Commission has also recently received calls from individuals in Lomond Ward, expressing concern about their care and treatment, specifically in relation to restrictions that had been placed on them.

We were keen to hear from individuals about their experience when admitted to the ward. The Commission has also recently been notified about a significant adverse event that occurred on the ward and were informed that a review was to be progressed. We will continue to follow up on this matter with the senior leadership team for this service.

Who we met with

We met with eight individuals and reviewed the care notes of seven people. We also spoke two sets of relatives.

We spoke with the clinical service manager, the senior charge nurse (SCN), the lead nurse, the consultant psychiatrist and ward staff. We also had the opportunity at the end of the visit to meet and feedback to the head of nursing and the interim senior manager for mental health, learning disabilities and addiction services.

Commission visitors

Tracey Ferguson, social work officer

Lesley Paterson, senior manager (practitioners)

Sandra Rae, social work officer

Graham Morgan, engagement and participation officer

What people told us and what we found

More than half of the people in the ward had been admitted in the previous six-month period prior to our visit. Some individuals had recently been admitted to the ward, while others had been in the ward for longer; the longest admission had been in the ward for nearly two years. We received mixed feedback from the people we spoke with, some provided positive feedback and others were less positive in their views.

We heard from several people about the uncertainty regarding their discharge from hospital and there were a few people who told us that they did not feel involved in their care and treatment. People told us that at times, the ward could be very noisy, with people shouting. They said it was difficult to find a quiet space due to the lack of privacy in the dormitory style bedrooms and a lack of quiet spaces and rooms in the ward. A few individuals told us that this had had an impact on their recovery as often there was nowhere to go.

One individual told us that they often witnessed staff being shouted at from people admitted to the ward and because of this, there were times that they did not feel safe on the ward. Another individual told us that they did not feel safe and did not like to witness others being 'pinned down' by staff. One person said that they did feel safe and that they were relieved to have been admitted and had felt better since their admission.

The majority of people told us that they were not happy at being in hospital, nor were they happy with their treatment. For those who were not happy at being in hospital, we wanted to ensure that people knew their rights; we were satisfied that people had been informed of these. Some individuals told us they had felt "controlled" by the statutory measures of their detention under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) and had accessed advocacy and legal advice to assist with their appeal against their detention under the Mental Health Act.

All of the individuals that we spoke with told us that they met regularly with the consultant psychiatrist and that this had provided them with the opportunity to discuss their treatment and express their concerns and objections, when they felt they wanted to. While everyone that we spoke with told us that they met regularly with the consultant psychiatrist, some said that they felt more involved than others throughout their recovery journey.

We had feedback about the staff on the ward, where people told us that there were regular staff, but that there were often staff that they did not know. A few individuals we spoke with told us that the nurses done their best, one described the staff as "great" and one as "staff were ok". Individuals told us that rarely, they had one-to-one sessions with staff. We heard that if individuals wanted to speak with staff, when

they knocked on the door to where the staff were based, they felt ignored. While some people recognised that staff were busy, others told us that this led to frustration as there were times they had repeatedly asked staff for specific things but were regularly told to wait.

A few individuals told us that they had signed their care plans recently after being in the ward for months.

Most people raised smoking as an issue as people smoked in the garden area. For non-smokers, they found this difficult as they did not want to access the garden area. We asked people how they spent their time on the ward and the majority of people told us that there was not much to do. They described their time on the ward as “boring” and told us that all there was to do was “lie around all day”.

One set of relatives that spoke with us said that they would have liked to have met with the doctor; we shared this information with the consultant psychiatrist, who met with the family on that day. Relatives described the ward environment as noisy, said that there was never enough staff on shift and that there seemed to be lack of stimulation and activities for individuals.

We were told there were seven registered mental health nurse vacancies and that bank staff were regularly used to fill shifts. The lead nurse told us that there had been an ongoing recruitment drive to fill the vacancies and that the plan was to recruit newly qualified nurses to these posts, with interviews taking place soon.

Due to the lack of staff and experience with the staff group, the lead nurse told us that some staff had been moved from another service area to Lomond Ward. This was to ensure there were adequate staffing levels and nurse who brought enhanced knowledge and expertise to the ward.

Care, treatment, support, and participation

The care and treatment on Lomond Ward was mainly provided by the nursing team as the ward did not have dedicated input from ward-based allied health professionals, such as occupational therapy (OT), psychology and physiotherapy.

We were told that the nursing team had to refer to allied health services if input was required for someone’s care and treatment. Similar to what we heard on last year’s visit, while the ward has funding for an OT post, the post had not been filled and remains vacant. We heard from the service that the absence of regular OT input was as issue, as this profession provided a valuable service for individuals who required functional assessments, recreational and therapeutic interventions.

The lead nurse informed us that there had been a number of complex cases where there was a specific need for psychology to become involved prior to discharge; this had been accepted but this was a rare situation when psychology would be involved. Again, we heard from the service that not having dedicated sessions from psychology often left the staff having to manage complex issues associated with people's care and treatment. We heard that not only were there individuals currently in the ward that would have benefitted from this input, but the staff would have too.

We were told that psychology would pick up referrals when a person was discharged to the community. The senior manager told us that a Situation, Background, Assessment and Recommendation (SBAR) report had been submitted to the senior executive team regarding having psychology input. We will request an update from the senior manager about the progress of this and of the vacant OT post.

Recommendation 1:
Managers should ensure that the ward has input from OT.

Recommendation 2:
Managers must ensure that there is psychology provision available to the individuals in the ward.

Care records
Care records were held on the electronic system, MORSE. We found this easy to navigate and were able to access the relevant documents. The ward also kept a separate paper folder of key documents for each individual.

Care planning
We wanted to find out how the ward had implemented our last recommendation about care plans. On our last visit to the ward, we were concerned individuals were not provided with care plans that were individualised, person-centred or written in collaboration with them. On the last visit, we were concerned to find that several individuals did not have any care plans that supported their admission to hospital or recovery.

The service had provided an action plan about how they planned to meet this recommendation. We were advised that the service was moving their health records audit process from paper-based to an electronic audit, which would provide the scrutiny and feedback for clinical team members to support improvement in this area of practice.

We were told that there had been work done on care planning and that the senior team had circulated the Commission's *person-centred care plans good practice guidance* across team. We were also informed that the service had a working group that were developing an improved format for person-centred care plans that would enhance individual engagement. We were advised that there was a care plan audit

tool in place, developed in older adult services and that the acute adult service was looking to adapt this tool to make this work for their service.

From reviewing the individual care records on the day of the visit, we found that the standard of care plans varied. Some were detailed and reviewed regularly, however this was not the case for all care plans. Similar to last year's visit, it was concerning to note that not everyone had a care plan in place, especially where people had significant needs.

Some care plans recorded that as part of the individual's care, the intervention was to build a therapeutic relationship and offer one-to-one sessions. We saw that some people had one-to-ones with nursing staff, however there were only a few records of those that we reviewed where this was documented .

While we saw some involvement of individuals in their care planning process, this was not consistently done in all the care plans we reviewed and it was unclear at what point throughout a person's admission when their care plans were discussed with them. We saw that where a few people has signed their care plan, they told us that they were asked to do this recently. We acknowledge that the service is in the early stages of developing an audit tool that will be appropriate to their service and we look forward to seeing how this development will progress at our next visit.

We will therefore repeat our same recommendation as last year.

Recommendation 3:
Managers should ensure that everyone admitted to the ward has a care plan in place that is detailed, person-centred and reviewed regularly and there is a regular audit process in place to improve the quality of the care plans, with evidence of individual and carer involvement/participation.

The Commission has published a good practice guide on care plans[1]. 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.

The standard of daily recordings in the nursing notes also varied. Most were descriptive and provided a detailed account of the person's overall wellbeing and mental state on that day but we also found that "individual at bed space most of day, had meals and meds" was frequently recording.

There were two people with do not attempt cardio-pulmonary resuscitation (DNACPRs) forms in place. On reviewing these, there was one where no reason as to why the DNACPR would not be successful was provided and the other one was

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

unclear about the review process. We requested of a review of these two individual certificates.

Recommendation 4:
Managers should ensure that where a person has a DNACPR in place that this is completed in accordance with the national policy.

Multidisciplinary team (MDT)
There was a multi-disciplinary team meeting (MDT) that took place weekly which consisted of the consultant psychiatrist and nursing staff. We were told that individuals and their named person or relative could also attend this meeting where appropriate.

We found that the recorded entries for the MDT meeting noted on MORSE provided a detailed account of individuals circumstances from week to week. The entries noted who was present at the meeting and recorded the outcome and any actions from the meeting.

Actions were reviewed on a weekly basis. There was clear record where the person attended the meeting or where they chose not to attend and had their views documented. The lead nurse and SCN told us that the service was looking to devise a new template that would be applied across the service. We look forward to seeing this on our next visit.

From reviewing the care records, we were able to see that the complex presentations of those who were admitted and we gained a sense that the only offer of treatment was medication. There were no psychological formulations or therapeutic approaches put in place or evidenced in individuals' care records. Many had experienced trauma, or presented with co-existing mental health and substance use problems, or emotional unstable personality disorder, or an eating disorder; for these individuals, they did not have input from a wide range of professionals that would support them in their care and treatment and would aid recovery and discharge.

We were told that there were five people who were ready for discharge from hospital but that their discharge had been delayed. We heard that the reason for delays varied, including problems with accommodation, care packages and legal processes. The longest delay for a person was 70 days. We were satisfied that each individual had an assessment that identified the next step from hospital.

Use of mental health and incapacity legislation

On the day of the visit, 14 people were detained under the Mental Health Act and all documentation relating to each individual's status was in place and recorded in the electronic record.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained and who are either capable or incapable of consenting to specific treatments. We found several issues with the completed treatment certificates (T2s and T3s) that authorised treatment under the Mental Health Act. We found that the treatment certificates did not always match with the medication being prescribed.

We made a recommendation during our 2023 visit regarding Part 16 treatment and although Lomond Ward had made progress since this visit, we were disappointed to find that this improvement had not been sustained.

We were told that there was a weekly audit in place to review the treatment certificates, although we heard that the audit system and checks were not working. We were concerned about this and the impact on patient's rights as some patients were receiving treatment out with the authority of the Mental Health Act. We will follow on these matters with the responsible medical officer (RMO).

Where individuals have received treatment out with the authority of the Mental Health Act we would expect the health board to notify individuals of this in writing to inform them of their rights and to ensure that their named person and their mental health officer (MHO) were also informed. We will follow up on the treatment issues with the senior leadership team.

Recommendation 5:
Managers must ensure that all psychotropic medication is appropriately and legally authorised and that regular audits undertaken to ensure significant improvement in this area is maintained. Consideration should be given to inhouse training to increase and improve staff knowledge in this area.

Under Part 16 (section 243) of the Mental Health Act, urgent or emergency medical treatment may be given to someone who is detained in hospital and who does not consent or is incapable of consenting and this treatment is deemed to be in a person's 'best interests' and follows the requirements of the Act.

The T4 certificate is completed retrospectively and is used by the RMO to notify the Commission of treatment given under section 243. The Mental Health Act requires the RMO to notify the Commission within seven days, so treatments given in this period of time should be included on a T4 form. From discussion with nursing and medical staff we found that there was poor understanding regarding the use of a T4 certificate.

We found several people had been prescribed 'as required' intramuscular (IM) psychotropic medication. This included individuals who had been detained and some individuals who were informal. The Commission has concerns about IM 'as required' psychotropic medication being included on a T2 certificates, as any advance

consent the individual has given is invalid if they have withdrawn their consent at a later time when the medication is given or if restraint is involved. It is the Commission's view that where IM medication has been prescribed on an 'as required' in hospital, it should be authorised on a T3 certificate.

We would also consider it best practice for a medical review to be arranged if there were exceptional circumstances where IM medication may be required.

Recommendation 6:
Managers should ensure intramuscular 'as required' psychotropic medication is not prescribed for informal patients, other than in exceptional individual circumstances and where that occurs, a medical review should be arranged for individuals who are not detained under the Mental Health Act.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 ('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 two section 47 treatment certificates in place but one had expired. We requested that the RMO to review this.

Where a patient had an appointed proxy decision maker in place under the AWI Act, we found the legal documentation in place. There was a white board displayed on the wall in the staff clinical area that recorded individual details and we were told that this was to provide a quick overview for staff. We suggested to the SCN that it would be beneficial for the board to also display information regarding the AWI Act.

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 in the file. We were aware that some individuals admitted to the ward may not have been able to nominate a named person at particular points of their admission, however this should be discussed with them throughout their admission and support for them to do so by the staff, the mental health officer (MHO) or advocacy.

We asked how peoples' monies were managed by the hospital when they were under the AWI Act. This information was not accessible, easy to locate or recorded in the individual's care records. While some peoples monies were been managed by the hospital, others appeared to have a Department of Work and Pensions (DWP) appointee in place. We could not locate the incapax certificate in the care records and were told that this certificate would be with the health board cashiers office.

Recommendation 7:
Managers must ensure that there is a system in place where a person's monies are being managed under part 4 the AWI Act and that this is clearly recorded in the individual's care records along with the certificate of incapax.

Rights and restrictions

Lomond Ward continues to operate a locked door and access to the ward is through a door entry system. Individuals and visitors can enter or leave the ward by asking a member of the ward team. There was no sign displayed about the door being locked or how people could access or come and go from the ward.

We asked about the ward's locked door policy given there was no sign on the door.

The lead nurse and SCN informed us that the door was not locked as there was a swipe system in place. NHS Fife has a procedure in place for locked doors in mental health facilities. Where a person receives their care on an informal basis, they should have free access and egress to the ward unless there are clinical reasons to alter this and details should then be documented in the individual's records. For those individuals in Lomond Ward, the locked door caused confusion as individuals were not able to come and go freely from the ward. We are aware that this policy was due for review in 2021 and this has not yet taken place. We will request an update from senior managers.

Recommendation 8:
Managers should have an up-to-date locked door policy in place and this should be displayed at the door of the ward to inform people about the reasons why the door is locked and how to gain access to and from the ward.

Individuals we spoke with had a good understanding of their rights. They had access to advocacy services and legal representation where required.

We wanted to find out how the service implements specified person procedures as we had been contacted from some individuals who had raised concerns with the Commission about the restrictions that were in place and the review processes.

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 made a specified person in relation to these sections of the Mental Health Act and where restrictions are introduced, it is important that the principle of least restriction is applied. We found all relevant paperwork was in place, along with reasoned opinions however prior to our visit, the Commission had made specific recommendations to the service with regards to the use of specified person legislation and will follow this up with the medical director.

The Commission has produced good practice guidance on specified persons[2].

When we are reviewing individual 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 one advance statement on file. We wanted to know how the health board was promoting these for individuals admitted to Lomond Ward, as we did not see any care plans or documentation that noted that a discussion had taken place with individuals. While we recognise that individuals may be not be able to make one at the time of their admission, we did not find any further discussions regarding making an advance statement in one-to-one sessions, or during care plans reviews or at the time of discharge. We suggested that advocacy services could support individuals, if appropriate, to make an advance statement.

At the entry point to the ward, a patients' rights pathway was displayed on the wall, which was informative and provided guidance. We suggested to the SCN that it would be beneficial to use the pathway when nurses were supporting people in developing care plans around their rights. We advised that this could be particularly helpful for those who were informal as we had observed that for these individuals, time out of the ward was restricted and it was unclear whether the person had agreed to this as this had not been documented in the care records.

The Commission has developed *Rights in Mind.*[3] 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 follow up on last year's recommendation about improvements that had been made in relation to activities and therapeutic engagement to enhance individuals' care and treatment.

Managers noted in the action plan that was returned after the last visit that staff would continue to create opportunities for therapeutic interventions and would do this through one-to-one sessions, as well as utilising their skills to deliver low intensity recreational activities. Unfortunately, we found that there was a lack of one-to-one sessions being offered and from reviewing the care records, there was no evidence of activities being offered.

Unfortunately, there has not been any progress with recruiting into an activity / recreational coordinator post. With a lack of regular occupational therapy, we remain

[2] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512
[3] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

concerned that individuals admitted to the ward do not have access to regular recreational and therapeutic activities.

The majority of individuals that we spoke with told us that the “days in the ward are long”. People voiced their ‘boredom’ and where some people were restricted and not able to leave the ward, they told us they would find regular activities helpful as part of their recovery.

We spoke with ward staff and although we heard about some activities such as decider skills and board games, these were not happening regularly as part of individuals’ care. We heard from staff that due to clinical demands in the ward, any activity that had been planned often did not take place due to other commitments.

We have highlighted our concerns about this on our last two visits and repeat our concerns again.

There was an activity room based off the ward. On the day of our visit, we saw one person being supported to play pool in the room. We asked a few people about access to this room and heard that they did not know they could access this. As the room is off the ward, individuals would require staff with them before they could access this room; independent access this room was not possible. The room was cluttered and if better organised, it would be a useful resource for individuals to have regular access to.

Recommendation 9:
Managers must consider the appointment of a dedicated activity therapist to ensure the provision of both individual and group activities across the ward.

The physical environment

The layout of the ward consists of six single bedrooms and four dormitory style rooms. There is a communal sitting area that has a few sofas and a television. There was a separate dining room off the corridor to the ward where meals were provided.

Individuals told us about the lack of privacy on the ward, particularly when they have to share dormitory rooms and bathrooms with others. People told us about the lack of quiet rooms and space in the ward, especially if they needed to get away from the noise on the ward. We heard how some people played music loudly in the ward and on the day of the visit, the majority of people were lying on their bed. One person told us how they liked sharing a dormitory as this was company for them.

On last year’s visit, we made a recommendation for the managers to consider the bed capacity for the ward. The lead nurse told us that although the ward still had capacity for 29 people, they had capped the number of bed usage to 22, however if there was a clinical need, two additional ‘surge’ beds were used.

Due to the ligature risks in the ward, a staff member is rostered to monitor the bedrooms and dormitories each hour as a way to manage and monitor risks. Lomond Ward has had some ligature reduction work completed in some of the single rooms and shower rooms. On the day of the visit, the communal bathroom and toilet was not draining. We found that some of the seals in the bathrooms were black and in need of an upgrade. We spoke to staff who shared our concerns about the ligature risk on the ward given individuals who are admitted to Lomond Ward.

We are aware that there are ongoing plans to upgrade the ward and that the Health Board had been awarded £12 million from the Scottish Government over the next 3 years as part of a refurbishment and upgraded programme of works. We will request an update from senior managers about progress with this.

The ward had access to a secure garden and to the extensive hospital grounds.

On the day of the visit, we were disappointed to see the garden being used by people who smoked. We asked the SCN about this, given that there is legislation in place about smoking within 15 metres of a hospital building in Scotland. We were told that it has been difficult to implement this however staff were continuing to remind people of the no smoking policy.

Recommendation 10:
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

Summary of recommendations

Recommendation 1:
Managers should ensure that the ward has input from OT

Recommendation 2:
Managers must ensure that there is psychology provision available to the individuals in the ward

Recommendation 3:
Managers should ensure that everyone admitted to the ward has a care plan in place that is detailed, person centred and reviewed regularly and there is a regular audit process in place to improve the quality of the care plans with evidence of individual and carer involvement/participation.

Recommendation 4:
Managers should ensure that where a person has a DNACPR in place that this is completed in accordance with the national policy.

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Recommendation 6:
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Managers should have an up-to-date locked door policy in place and this should be displayed at the door of the ward to inform people about the reasons why the door is locked and how to gain access to and from the ward.

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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.

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