Mental Welfare Commission for Scotland

Report on unannounced visit to:
Whyteman's Brae Hospital, Ravenscraig Ward, Kirkcaldy, Fife, KY1 2ND

Date of visit: 27 and 28 November 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

Ravenscraig Ward is a 21-bedded, mixed-sex, adult acute admission unit in Kirkcaldy, Fife. On the day of the visit there were 20 people in the ward.

The ward is based on the site of Whyteman's Brae Hospital and is the only inpatient service on this hospital site; it covers the catchment area of central Fife. On our last visit the ward admitted up to 29 people; we were pleased to hear of the reduction in the number of people being admitted to this acute ward. The senior charge nurse (SCN) told us the ward continued to have bed space for 29 people, however an agreement had been made with senior managers that the maximum number of people being admitted was capped to 23 people, which included two surge beds.

We last visited this service in January 2024 on an announced visit and made recommendations relating to person-centred care planning and the daily records kept by nursing staff. We also made recommendations that included authorising treatment for individuals subject to Mental Health (Care and Treatment) (Scotland) Act, 2003 (Mental Health Act) legislation. We had highlighted again in the 2024 report, our concerns about the ward environment and the need for funding and investment.

We received a response from the service that was outlined in a detailed action plan as to how the service planned to meet the recommendations.

Prior to this visit, senior managers of NHS Fife and the Health and Social Care Partnership (HSCP) informed the Commission that a decision had been made for Ravenscraig Ward to move to the Queen Margaret Hospital site following the refurbishment of a vacant ward. We were informed that this move is likely to happen towards the summer months and therefore we will continue to request updates from senior managers.

On the day of this visit, we wanted to follow up on the previous recommendations and find out about people's experience of being admitted to Ravenscraig Ward, and the challenges that staff continued to face. In our 2023 report, we had also made a previous recommendation about the lack of therapeutic activity provision and were informed on our visit in 2024 that there was going to be investment in activity provision across all mental health wards. We wanted to find out about the range of therapeutic activities that were in place to support people with their recovery.

Who we met with

We met with 10 individuals and reviewed the care records of nine of those people. We also reviewed the care records of another individual who we did not meet with.

As this visit was unannounced, we did not meet with any relatives over the two days. We therefore requested the SCN to inform relatives of the visit to allow anyone to contact the Commission following the visit if they wanted to speak with us.

We spoke with the clinical services manager, the lead nurse, the consultant psychiatrist, the SCN, the charge nurse, other nursing staff and the student nurse.

We also met with senior leaders from NHS Fife at our feedback session.

Commission visitors

Tracey Ferguson, social work officer

Lesley Paterson, senior manager (east team)

Susan Tait, nursing officer

Susan Hynes, nursing officer

Alison Thomson, nursing officer

What people told us and what we found

Throughout the two days of the visit, we introduced ourselves and chatted with most of the individuals in the ward. As the visit was unannounced, the two-day visit provided people with more of an opportunity to meet with us, as they had not received any prior notice of our visit.

Individuals were at different stages of their recovery; some individuals had recently been admitted to the ward while others were at the stage of discussing and preparing for discharge. There were quite a few people who had more time off the ward as part of their care planning.

When individuals are admitted to the ward they are provided with a leaflet with information about what to expect on admission; mealtimes, housekeeping, activities and valuables. This leaflet also had QR codes that individuals could access should they wish to get more information about their rights and advocacy.

Most people's feedback was positive about the staff. They described staff as "nice and approachable", "brilliant", "marvellous" and "passionate". One individual told us that they were "treated like a human being". A few people told us that staff were very busy, but no matter how busy they were, when they told you they would get back to you, and they did.

Several people told us that they had regular one-to-one discussions with staff, even where the individual did not really want to have one; they thought it was good that staff were checking in on them. Individuals told us about their progress and discharge plans and how they felt involved in their care. We heard from others that they could attend the multidisciplinary team (MDT) meeting regularly, which made them feel involved in their care and treatment.

Some individuals told us that they had been involved in their care planning, while others told us that when they were first admitted they did not want to participate in this. However, when we heard from those individuals who initially did not want to be involved, they told us that as they recovered, there were opportunities to become involved and to be part of their care and treatment.

In terms of the environment, some of the females told us that they did not feel safe in the ward, while others told us that they did. Individuals told us that their experience would often depend on who else was in the ward with them.

A number of people told us that at times, the ward could be noisy and sharing dormitories could be difficult due to the lack of privacy. We got the sense from speaking to individuals that most people knew about their rights, however for two people we spoke with who had recently been admitted to the ward on an informal basis, they were not as well informed of their rights. They told us that they had no

time out from the ward, were unsure about their rights and felt restricted. Many people told us about the lack of activities and how this led to boredom. People told us that sometimes there were activities planned but that these did not always happen if staff were busy or had to deal with other matters. Everyone we spoke with told us that there was a board displayed in the corridor with activities planned for each day.

We spoke to most of the staff over the two days, and they told us that there was good teamwork in place. The student nurse told us about their experience of the placement and that the ward and team had provided a positive learning environment. From speaking to the staff, we got the impression that they knew and took the time to get to know the individuals on the ward well, including those recently admitted. Throughout the visit we saw caring and supportive interactions between staff and individuals and where situations had to be de-escalated, we saw staff approach this sensitively.

Staff told us they were looking forward to the move to Queen Margaret Hospital. We found that there was good leadership in place with clear information of roles, responsibilities and ownership of tasks. The ward had a designated floor nurse each day and we were told about their role and remit. The SCN informed us about the various audit processes in place to improve standards.

Ward based staff told us that there were occasions where some staff may have to be moved to other areas due to needs in another clinical area, which meant the staffing levels would often go into 'amber', directly impacting on staff being able to deliver some aspects of care, such as one-to-one discussions and activities.

We were told that on each shift there would tend to be eight staff, which included three registered nurses and five health care support workers (HCSWs).

We are aware that the health board are undertaking work with Healthcare Improvement Scotland to ensure safe staffing levels and that the ward is required to meet the obligations of the Health and Care (Staffing) (Scotland) Act, 2019.The lead nurse and SCN told us that in order to ensure safe staffing levels were in place there was a staff huddle each morning between senior staff; this was to ensure wards had sufficient staffing to meet the clinical needs and demands in each area.

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. However, as documents were stored under specific sections we were told that it could be difficult to find where documents were stored, as it would depend on where the staff member who started the document had stored it. While on another local visit to a service in Fife,

senior managers had informed us that this was being looked at and we will continue to request updates during our local visits.

Care, treatment, support, and participation

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

We wanted to follow up last year's recommendation around care planning. We found that the care plans were mostly detailed and holistic, covering a wide range of needs, and while most were personalised, we found a few that would have benefitted from personalisation. We found that the care plans were being reviewed regularly and most had a good level of detail recorded following that review.

We found that there had been progress around care planning since our last visit, and that people had been involved in this process. We advised that it would be good for staff to build on this progress and evidence the person's involvement, along with recording their views at the care planning review stage, as the recorded evidence was lacking.

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.

We wanted to follow up on the daily recording as on our last visit we found that the records were not always meaningful and that often there was a lack of description of the individual's presentation. In daily continuation notes we would expect to see evidence of an individual's progress, contact with their keyworker or engagement in ward-based therapeutic/recreational activities.

We found on this visit that there had been a significant improvement in the daily recordings. We found that the daily records were detailed and a new pro forma that was now in place enabled this level of recording to be captured in a way that provided a holistic update regarding individuals presentation on that day.

We noted that individuals were offered regular one-to-one meetings and staff recorded when people participated in these, or if they refused, or if those meetings did not happen for any reason. These recordings gave a fuller, more detailed account of the individual's presentation, and staff documented how the person benefitted from the sessions, along with detailed recordings of the individual's views about their admission, their care and treatment goals. We advised that those meetings could provide an opportunity for staff to discuss the care plan reviews with the

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

individual. We would have liked to have seen more discussions about individuals' rights in the one-to-one sessions.

We found the initial assessments completed by medical and nursing staff to be thorough and comprehensive, with a recorded plan of action regarding the purpose of admission and what it hoped to achieve.

Assessments of admission were detailed and included a senior medical review. For individuals admitted on an informal basis, the record would have benefitted from the clinician incorporating the person's views of admission, particularly as the ward was locked and some individuals' time off the ward was restricted.

All of the care records we reviewed had a risk assessment in place and these were mostly detailed, however, the risk management plans varied in the level of detail. We also found that some of the reviews lacked detail; it was unclear if the risk was being managed or if the intervention that had been put in place to manage the risks was effective.

Recommendation 1:
Managers should ensure that all risk management plans provide a detailed account as to how each risk will be managed along with evidence of ongoing review of the risks.

Multidisciplinary team (MDT)
We were told that there were five consultant psychiatrists who provided input into the ward and of those five, three had recently taken up post on a locum basis. Those consultant psychiatrists also covered a specific geographical area in the community and were responsible for that person's care and treatment on admission.

We were told that the MDT met weekly, with each consultant psychiatrist holding their own separate MDT meeting. There was an MDT meeting held each day between Monday and Thursday.

The professionals who attended those meetings mainly consisted of nursing staff and the consultant psychiatrist. We were told that there was also regular attendance at those meetings from community staff, including community psychiatric nurses and mental health officers (MHOs), when necessary. The record of the MDT meeting was held in MORSE. We found the meeting records to be detailed and clearly identify attendees and captured their views. The record of the meeting summarised the individuals' weekly progress and provided a good account of the person's ongoing mental and physical health care.

The format of the electronic record provided the clinical team members with sufficient prompts to ensure specific aspects of the care and treatment were

covered. An example of the prompts included treatment forms, medication, legal status and time out of the ward.

We also saw evidence that where some individuals did not wish to attend the meeting, the reasons for this recorded, although for those who did not attend, we could not see where any specific requests by them were recorded; we suggested to the SCN that this should be evidenced on the MDT meeting record and in the regular one-to-one meetings.

Where people wanted their relatives involved, we saw how this took place as part of the MDT process and found that discussions were happening between nursing staff and relatives out with the meeting.

In terms of physical health care monitoring, we were told that this was carried out by the consultant psychiatrist or the resident doctor. We found that there was ongoing monitoring of people's physical healthcare from the point of admission, which was what would be expected. We saw individuals being supported to continue to access other healthcare provisions, such as opticians and dentists while in hospital.

The wards did not have a dedicated OT, however we were told that any OT referrals were actioned quickly and that most referrals were for functional assessments, mainly to support discharge planning. We could see evidence of this in the care records which detailed the purpose of OT involvement and the plan of action around this. For individuals who required additional support from other AHPs, we were told that referrals were made to services, such as physiotherapy, dietician or speech and language therapy.

We asked about the input with regards to psychology provision, as we would expect that all acute admission wards have timely access to psychology input; this was not the case for Ravenscraig Ward.

We were aware that nursing staff had received training in specific psychological therapies. However, we felt that there were individuals in the ward who would have benefitted from psychology input, which could also have provided support to the nursing staff.

We were told that psychology would pick up referrals when a person was discharged to the community. The senior manager told us on a previous visit to another acute admission ward that an SBAR (situation, background, assessment and recommendation) report had been submitted to the senior executive team regarding psychology input across adult wards. We will request an update on the progress of this from the senior management team.

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

Following our review of one individual's care and treatment, we requested that input from psychology was sought in order to aid discharge, given the previous discharge had not been successful.

With regards to people who were in hospital awaiting discharge, we were told that the clinical services manager and the discharge co-ordinator met fortnightly to discuss peoples' discharge pathways and to identify any potential challenges early on in the persons admission, which would enable progress to be made. We were told that there was one person in the ward whose discharge was delayed.

Use of mental health and incapacity legislation

On the day of the visit, eight people in the ward were detained under the Mental Health Act. All documentation relating to detention status was easy to locate on the electronic system.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. We wanted to find out what action the service had taken with regards to meeting the recommendation that we made on last year's visit around treatment.

We reviewed all consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act. We were disappointed to find several issues with the treatment certificates that authorised treatment under the Mental Health Act. We found that the treatment certificates did not always match with the prescribed medication. This meant, that in some cases, psychotropic medication was being administered without legal authority.

We were told that there was a weekly audit in place to review the treatment certificates, in line with the prescribed medication for individuals and that there was a process to escalate matters where required. We found a few instances where nursing staff escalated matters to the consultant psychiatrist, however no action was taken to rectify matters.

Despite three different regular audits being carried out by staff nurses, charge nurses and pharmacy staff, the errors and omissions persisted with no resolution. We were concerned about this and the impact on the rights of the affected individuals. Where individuals had received treatment out with the authority of the Mental Health Act, we would expect the responsible medical officer to notify individuals of this in writing to inform them of their rights and to ensure that their named person and their

MHO were also informed. We will follow up on the treatment issues with NHS Fife senior leadership team. As this recommendation was not met, we will repeat it.

Recommendation 3:
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 and that any escalated matters are addressed. Consideration should be given to inhouse training to increase and improve staff knowledge in this area.

We wanted to find out if any individuals who had been admitted to the ward on an informal basis had been prescribed and administered 'if required' intramuscular (IM) psychotropic medication, as we had raised concerns about this practice from another recent visit in Fife. Administration of 'if required' intramuscular (IM) psychotropic medication almost always requires the legislative authority of the Mental Health Act. The Commission is concerned when IM 'if required' medication is being prescribed for informal patients. This is because it is unlikely that there would be consent to receive this treatment if it had to be administered in circumstances where restraint may be required. We consider it best practice for a medical review to be arranged if there are exceptional circumstances where IM medication may be required. We were pleased to see that no one who had been admitted informally to the ward had been prescribed or administered 'if required' IM medication.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act (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. We were told that there was one person in the ward where a section 47 certificate was in place and we asked for this to be reviewed as there was no treatment plan in place.

We were told that there were no individuals who were subject to a welfare guardianship or power of attorney under AWI Act legislation and that no individuals finances were being managed under Part 4 of the AWI Act.

Rights and restrictions

On the day of our visit, there were no individuals in the ward who required to be on continuous intervention.

The door to the ward was locked; there was a locked door notice at the entrance to the ward and the locked door policy displayed on a wall in the ward. We were aware from another visit that the locked door policy was being reviewed, and we will seek an update from senior managers about this.

For people who were detained under the Mental Health Act, this provided the authority for the person to remain in hospital. However, for people who had been admitted informally, we felt that some individual records lacked any discussion about individual rights. It was, at times, unclear if the person had given consent and was willing to remain on the ward. We also found two records that recorded; "if …… attempts to leave, Mental Health Act needed" and "if…… not willing to stay, then detain". In our view this could be considered as de facto detention and would impact on a person's rights.

We also requested the consultant psychiatrist urgently review one individual's care and treatment as that individual was admitted to the ward informally and had asked to leave on several occasions over our two-day visit. We will follow up on these matters and request updates.

Our view would be that conversations about individuals' rights, especially in terms of their views on their admission to the ward need to be better evidenced in the care records and in the care planning process.

Recommendation 4:
Managers must ensure that rights-based care is delivered to individuals and that all restrictions placed on individuals throughout their admission are legally authorised, reviewed regularly and discussions regarding restrictions and consent are clearly documented.

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. There was ample information displayed on the walls in the ward about people's rights. We suggested to the SCN that it would be beneficial to use the pathway when nursing staff were supporting people in developing care plans around their rights and in the regular one-to-one sessions. We advised that this would be particularly helpful for those who were admitted to the ward on an informal basis.

The ward had CCTV in place, with a camera in one of the corridors that led to the fire exit door. Staff were able to view the CCTV in the staff office and in another room on the ward. We were told that no one manned the CCTV, and there could be occasions when police requested this. We were told that the CCTV had been there for many years and that there was no place to incorporate this equipment into the design of the new located ward.

From reviewing one person's care record, we found that the staff were undertaking drug urine analysis and it was unclear if the person had consented to this or not, due to their views not being recorded. We followed this up and were made aware that the

person had consented to this but felt that this required to be better reflected in their care records.

The ward had good support from the local advocacy organisation, Voiceability and we were pleased to find that this service was available for everyone and not just for people who were detained under the Mental Health Act.

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

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 a person is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. No one in the ward had been made a specified person.

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 in the care records of where staff had promoted and discussed advance statements with individuals.

Activity and occupation

We would expect to see person-centred activity programmes which are based on a multidisciplinary assessment of each individual's needs and strengths. Such a programme should include options for activities both on and off the ward, where appropriate for therapeutic and recreational activity and reflect the social, cultural and religious preferences of each individual.

We wanted to follow up from our visit last year and find out about the investment that the NHS Fife had made in activity provision in this ward, to support people's recovery.

The ward did not have a dedicated activity therapist in place and there was no provision in place from AHPs to provide this either. We were disappointed to find that there had been no investment since our last visit to rectify this. Activity provision was being delivered by the ward-based staff, however the availability of this was dependant on clinical activity. We were told that there was a HCSW who had responsibility each day to carry out activities and while we saw activities happening over the two days of our visit, in talking to staff, they told us that activities would tend to be the first task to go if staff had other clinical priorities or were required to cover other areas.

We spoke to people who told us about some of the activities they engaged in, and others who told us that they were often “bored” as not much was happening. People told us about the time they spent off the ward and that they enjoyed this.

We continue to be concerned about the lack of activity provision and requested a further update from senior managers. We were told that there had been ongoing discussions with the AHP manager about the repurpose of posts across the health board in order to contribute and deliver therapeutic activity provision across wards. We were informed on this visit that approval was now in place to go ahead with creating posts, and these posts had already gone out for advert. We were also informed that these posts were from existing funding. We will continue to request an update from senior managers and look forward to seeing the implementation of activity provision across all the wards.

The physical environment

The layout of the ward consisted of single bedrooms and dormitory style areas. There was a communal sitting area that had sofas and a television. There was a separate dining room off the corridor to the ward where meals were provided. We were told that some people preferred to have their meals in the ward, which meant staff had to bring their meals to them. While some individuals told us that they did not mind sharing their bedspace with others, some told us that there was a lack of privacy, particularly when they had to share dormitories and bathrooms.

Although there were quiet rooms, people told us about the lack of space in the ward, especially if they felt they needed to get away from the noise and find a quieter place.

We discussed one person’s bed space with the SCN as the individual had shown us the uncleanliness of the drawers. We requested that this was attended too.

There was access to an enclosed garden that had steps leading to it from the ward. While we saw some people utilise the garden on the day of the visit, most people we saw used this space for vaping and smoking. We were disappointed to see the garden being used by people who smoked, and we also heard this discouraged other individuals from using it. We asked the senior managers about this, given that there is legislation in place which prohibits smoking within 15 metres of a hospital building in Scotland. We were told that it had been difficult to implement this however, staff were continuing to remind people of the no smoking policy and managers were considering how to address this when the ward moves to the Queen Margaret Hospital site in Dunfermline.

Recommendation 5:
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

Recommendation1:
Managers should ensure that all risk management plans provide a detailed account as to how each risk will be managed along with evidence of ongoing review of the risks.

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

Recommendation 3:
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 and that any escalated matters are addressed. Consideration should be given to inhouse training to increase and improve staff knowledge in this area.

Recommendation 4:
Managers must ensure that rights-based care is delivered to individuals and that all restrictions placed on individuals throughout their admission are legally authorised, reviewed regularly and discussions regarding restrictions and consent are clearly documented.

Recommendation 5:
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.

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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