Mental Welfare Commission for Scotland

Report on announced visit to:

The Royal Edinburgh Hospital, Craiglea Rehabilitation Ward, Morningside Road, Edinburgh, EH10 5HF

Date of visit: 8 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

Since the Commission's previous visit to the female rehabilitation ward at the Royal Edinburgh Hospital in January 2023, there have been several changes to the rehabilitation service. At that time, the female rehabilitation ward was known as Myreside Ward. We were informed that these changes were implemented in response to increased demand for inpatient rehabilitation care, treatment and support for male patients. The waiting list for male admissions had been increasing, resulting in prolonged stays in acute wards while male individuals awaited a rehabilitation bed.

In January 2025, the service was restructured and female patients previously accommodated in Myreside Ward were transferred to Craiglea Ward, a 13-bedded unit. Myreside Ward was then designated as a male rehabilitation ward, with capacity for 18 beds to address the increased clinical demand for male placements.

The senior charge nurse (SCN) advised that the change had had a positive impact on the individuals now residing in Craiglea Ward. We were told that the reduction in bed numbers to 13 had allowed for a more spacious environment, which the women had responded to positively. Encouragingly, staff reported that the new environment had contributed to a reduction in incidents of violence and aggression.

Referrals to Craiglea Ward were received from several sources, including inpatient adult acute, community, and forensic mental health services. The objective of Craiglea Ward was to provide intensive rehabilitation to individuals with complex and enduring mental health needs, with the aim of preparing and supporting individuals to be discharged into the community.

We saw and heard during the previous visit that many of the individuals had reached their rehabilitation potential from hospital-based care and were inappropriately placed in the ward. We were pleased to be told that the referral process for rehabilitation services had been reviewed and that the multidisciplinary team (MDT) had implemented a consistent approach to assessing referrals and ensuring that every referral had a clear focus on the potential rehabilitation benefit for the individual.

Some individuals referred to Craiglea Ward had had contact with mental health services for a prolonged period; the longest admission had been 12 years. We were pleased to be told that several individuals had been discharged from the ward since the previous Commission visit. We heard that a further three individuals were preparing for imminent discharge and that two individuals' discharge had been delayed due to a lack of community care supports.

During our last visit to this service in January 2023, we made recommendations on boarding arrangements, ensuring all consent and authority to treat certificates were valid, staff shortages and concerns over the environment.

On the day of our visit, there were 13 people on the ward and no vacant beds. We wanted to follow up on the previous recommendations, meet with individuals, relatives/carers, staff and view the new ward environment.

Who we met with

We met with nine people and reviewed the care records of seven. We also met with four relatives.

We spoke with the chief nurse, clinical nurse manager (CNM), the SCN, other nursing staff, the psychiatric registrar, lead psychologist, occupational therapy (OT) staff and the art psychotherapist.

Following the visit, we contacted social work staff and met with the head of service and the service manager for mental health services.

Commission visitors

Kathleen Liddell, social work officer

Dr Juliet Brock, medical officer

Susan Hynes, nursing officer

What people told us and what we found

The individuals we met with on the day of the visit were mainly positive about their care, support and treatment in Craiglea Ward. Their feedback included comments such as “staff are kind and helpful”, “staff are nice to me”, and “staff are supporting me to be discharged into my own flat, which I am very happy about”. We heard from individuals that they felt some staff adopted a more supportive and proactive approach than others. However, every individual that we spoke with was able to identify staff members in the MDT who they felt supported their care and treatment needs.

One individual raised concerns about the ongoing ‘boarding arrangements’ across the hospital site. This issue had also been identified during the previous visit, and a recommendation was made to the service at that time. The individual reported returning early from pass to find another individual occupying their bed. We heard that the individual was initially advised they would need to move to another ward however, they declined and were subsequently able to return to their bed. The individual expressed dissatisfaction that another person had accessed their bedspace where they stored personal belongings and described this as an invasion of privacy.

We raised this issue with the CNM and SCN and were advised that boarding admissions to Craiglea Ward had reduced however, there were occasions when individuals were admitted to the ward on a boarding basis due to continued bed pressures across the hospital site. While we acknowledge these pressures, we remain concerned that boarding arrangements are continuing to have a negative impact on individuals in the hospital.

All individuals told us they had a key nurse that they met with them regularly. Most individuals were aware of their care plan and told us they had participated in the completion of it. These individuals told us that they had access to advocacy services and that they had provided their views to the MDT during the weekly MDT meetings and at the three-monthly integrated care pathway (ICP) meetings.

We heard from some individuals that they did not always agree with decisions made by the MDT, mainly in relation to pass arrangements however, from discussions with the SCN and review of the care records, we were able to see that decisions made were proportionate to the assessed needs and risks and that the MDT had discussed the rationale for the decision with the individual.

Many of the individuals we met with told us they felt frustrated at the amount of time they had been in hospital. Some individuals did not feel as though they needed to be in hospital and were concerned there was no discharge planning in place for them.

All the individuals we met with provided positive feedback on the activities available in and out with Craiglea Ward. Individuals spoke positively about the activities provided by OT staff. We were told that the activities that were available promoted individuals' hobbies and interests, as well as developing and supporting their rehabilitation needs. We heard from many individuals that they attended activities in the community, providing them with the opportunity to build their connections with local services.

Some individuals raised concerns about the environment. Many of the individuals we met with shared a room with no en-suite facilities. We heard from individuals that they felt their privacy and dignity was compromised.

Relatives we spoke with provided mainly positive feedback regarding the care, treatment and support their loved one was receiving in Craiglea Ward. We heard comments including "the care is excellent" and that this was the "most well" their loved one had ever been. Many relatives commented that their loved one's quality of life was better in Craiglea Ward as they had access to good care and regular activity.

Most relatives raised concerns over discharge and supports in the community. We heard that relatives were happy with discharge planning, however, were concerned that there were insufficient resources and supports in the community to support ongoing recovery and prevention of further re-admission to hospital.

All relatives told us that their contact with staff in the ward was positive and that communication was very good. We heard that staff "always made time" for relatives when they had a question or concern. We were told that relatives were invited to attend MDT and ICP meetings and for those who attended, they generally felt listened to and involved in discussions and the decision-making for their loved one's care.

We heard from relatives that the SCN was "amazing" and "very supportive". They commented that the SCN's strong leadership contributed to a positive working ethos and culture in the team.

We discussed the use of restrictions with relatives and received mixed feedback. Some relatives told us they felt their loved ones' "freedom and independence was promoted". However, others expressed concern that certain restrictions, particularly those relating to passes off the ward, were not always necessary. Some relatives reported that they had raised these concerns with the MDT but did not feel their views were listened to or that they were fully involved in related decision-making. We discussed this feedback with the SCN, who advised that the service was aware of these concerns and had engaged with the families involved to explain the reasons for the restrictions.

Most relatives we spoke with raised significant concerns over the ward environment. We heard comments including, “the building is a disgrace”, “the facilities do not support rehabilitation interventions” and “the lack of garden space is appalling, especially for people who do not have pass”. There was a view shared among all relatives that we spoke with, where they advised us that the recovery of their loved ones would be better supported in an environment that offered appropriate and sufficient facilities to meet their complex physical and mental health needs.

The service had information available for carers on an information board at the entrance of the ward. The board provided excellent information on carer supports available, advocacy, benefits and adult care and support plan information. The service also organised a carers group facilitated by two of the SCN’s in the rehabilitation service. We heard that the service was reviewing the carers group and considering new approaches to ensure the group was more widely accessible to carers.

We met with various members of the MDT during the visit. Most of the staff we spoke with told us that they enjoyed working in Craiglea Ward. We were pleased to hear that staff numbers had increased since the last visit with a high level of staff retention. We heard that many of the newer staff employed had been student nurses in the ward and were now employed in permanent posts. We heard that some staff sickness and maternity leave had left gaps in the team however, these shifts were covered by permanent staff and consistent bank staff.

We heard that training and skills development was actively promoted and encouraged to support staff in enhancing and maintaining the specialist knowledge and competencies required for mental health rehabilitation. Staff told us that they had undertaken additional training to support physical healthcare needs, such as vital signs monitoring and electrocardiogram (ECG) training.

Some staff expressed concerns about the ward environment and the potential negative impact it may have on providing effective rehabilitation care. While we observed that the team had made efforts to create a homely and comfortable environment, the physical environment of Craiglea Ward was not well suited to meet the complex needs of the individuals being care for. Staff highlighted particular issues, including a lack of privacy due to shared bedrooms, limited access to appropriate washing and toileting facilities, and lack of access to garden space.

Care, treatment, support, and participation

We were told and saw that NHS Lothian had implemented a new person-centred care plan in April 2025. The SCN told us that although the introduction of the new care plan system had been a significant transition for staff, the team felt positive that the new care plan format was more beneficial for individuals. Staff also reported that the training provided to support implementation had been very helpful.

We heard that all individuals had a person-centred care plan in place. However, the SCN advised that recent audits had identified the need for ongoing support and training to ensure all staff completed care plans to a consistently high standard.

The new person-centred care plans reviewed on TrakCare had various headings, for example, mental health, stress and distress, activities of daily living, legislation, substance misuse, physical health, risk, activity, discharge planning and carer/family involvement. The Commission would expect a rehabilitation service care plan to be underpinned by a whole-systems approach, with a clear focus on recovery. We were satisfied that the newly implemented care plans reflected and supported this model of care.

The care plans reviewed were mainly of a good standard. We saw some examples of care plans that clearly documented the individuals' goals and specific aims, along with the interventions required by the MDT to support the individuals to achieve these. All care plans reviewed were individualised, goal focussed, and person-centred which was supported by the completion of the 'what matters to me' section and 'staying well' plan. We saw that individuals and relatives/carers had been involved in the completion of the care plan.

We found that care plans we reviewed adopted a strengths-based, holistic and rights-based approach. There were some inconsistencies in relation to the level of detail recorded and there were care plans which would have benefitted from recording more detailed information. We discussed this with the SCN who agreed that ongoing work and training was required to ensure all care plans were completed to the same high standard.

We saw that care plans were being reviewed regularly however, we were disappointed by the lack of comprehensive information recorded. We were unable to determine any progress made towards rehabilitation recovery and how this had been supported by the MDT. We raised this issue with the senior management team and heard that following the implementation of the new person-centred care plans, the review process was at an early stage of development and acknowledged that further work was required to ensure reviews effectively evaluated and evidenced the individual's progress.

In addition to care plans, all individuals in Craiglea Ward had a completed ICP document. We found the ICPs contained comprehensive and detailed information that reflected a holistic approach to care and treatment. The documentation included psychological formulations and demonstrated the involvement of the individual, their family, and all members of the MDT. We were satisfied that key information relating to care, treatment, and support was clearly documented and easily accessible within the ICPs.

We saw that some of the individuals in Craiglea Ward had been in hospital for a prolonged period. The Commission's [2020 report on rehabilitation services] highlighted the link between long-term mental health problems and an increase in physical health problems.

We heard that medical and nursing staff regularly advocated on behalf of individuals in Craiglea Ward to ensure they received appropriate and timely healthcare in accordance with their rights to equitable and person-centred treatment. For example, the SCN described a situation in which the service advocated for an individual to access chemotherapy, demonstrating a clear commitment to upholding the individual's right to health, dignity, and equal access to medical care.

From our review of the care records, we found that some of the individuals in Craiglea Ward had complex physical health care needs and we were pleased to find that there was a significant focus on physical health care, with evidence of these particular needs being addressed and followed up by medical staff. We also saw evidence of individuals being supported to attend routine and national health screening appointments which is essential in reducing health inequalities for individuals in hospital.

On review of the care plans, we found evidence of a culture that supported a healthy lifestyle, particularly in relation to diet, exercise and mental well-being. The OTs in Craiglea Ward provided opportunities for individuals to engage in regular exercise and support with diet and nutrition. We were pleased to see that individuals were being offered regular input from spiritual care to promote spiritual well-being.

We saw that there was a focus on promoting a smoke-free environment and supporting individuals with smoking cessation following the implementation of the legislation prohibiting smoking in hospital grounds. The ward displayed information materials detailing the smoking cessation support offered to individuals. We heard that individuals had provided suggestions on how they could be better supported to reduce smoking. We were pleased to hear from some individuals that they had stopped smoking since admission to Craiglea Ward.

We were told that two individuals in Craiglea Ward experienced delays in their discharge, primarily due to a lack of available resources in relation to housing options, specialist residential placements or third sector community supports. We were encouraged to be told by social work managers that these individuals had allocated social workers, and proactive approaches were being taken to support discharge planning.

We were pleased to hear and see that the MDT adopted an assertive and proactive approach to discharge planning. We were told that the community rehabilitation team (CRT) had previously provided transitional discharge support however, staffing

shortages in the CRT had resulted in a gap in this provision. We heard that in order to attempt to maintain continuity of discharge support on an interim basis, funding was allocated for a Band 4 post in Craiglea Ward to undertake an outreach role until the CRT reached full staffing capacity. However, following our visit, we subsequently heard from a member of the clinical team that this temporary provision was not sufficient to meet the needs of all individuals in Craiglea Ward, and the matter had been escalated to senior managers. We will seek an update on progress around this in due course.

OT staff also described their active involvement in discharge planning, including supporting individuals with practical skills, such as bus travel training and community integration. Furthermore, we heard that OTs continued to engage with individuals following discharge to support the implementation of community-based care plans.

We found risk assessments to be of a high standard and the assessments included a chronology of risk, triggers, stressors, protective factors, and a risk management plan with clear strategies to manage the assessed risks. We found that the information linked to outcomes in the risk assessments completed as part of the ICP. We saw that risk assessments were reviewed regularly.

Care records

The care records were recorded on TrakCare using a pre-populated template with headings aligned to the person-centred care plans, helping to ensure consistency and continuity in achieving care, treatment and support outcomes.

From our-review of the care records, we saw that some individuals in Craiglea Ward had complex mental and physical health needs and required high levels of staff motivation to engage in their care plan. We saw that all members of the MDT were involved in providing regular prompting and support to individuals in Craiglea Ward to support them to engage in their care plan goals to promote their recovery.

We found the information recorded was mainly comprehensive, individualised with information being recorded by all members of the MDT. The information recorded was person-centred, strengths-based, outcome and goal focussed. It was evident from reading the care records how individuals had spent their day, which MDT members had undertaken interventions with them and the outcome of interventions.

The individuals we met with told us that they met with their key nurse and other members of the MDT regularly. The one-to-one interactions reviewed were comprehensive, personalised and strengths-based. We saw positive and regular examples of staff promoting rights-based care by having discussions with individuals regarding views on their care plan, future planning and any issue of concern.

We were pleased to find that the care records included regular communication with families, welfare guardians and relevant professionals, including community teams.

Multidisciplinary team (MDT)

The ward had a broad range of disciplines either based there or accessible to them. In addition to the nursing staff, there was a consultant psychiatrist, psychiatric registrar, junior doctors, pharmacy, a psychologist, an art psychotherapist and OTs. We heard that the ward clerk, housekeeper and domestic were also valued members of the MDT. We saw that the MDT had good links with mental health officers (MHOs).

We met with the psychologist and heard, as well as observed that individuals were offered psychological input on a one-to-one basis and in group settings. We were told that there had been a reduction in psychology provision to Craiglea Ward due to staff shortages however, a psychology assistant had been recruited to start imminently. We heard that due to a lack of psychology provision, the interventions tended to be for individuals who required one-to-one support. We heard that when psychology capacity increased, there was a plan to introduce group work.

The psychologist attended MDT meetings and ICP meetings and individuals who required one-to-one support were identified at these meetings. Psychological formulations were completed as part of the ICP process and supported a collaborative approach to the individuals' care, treatment and support by developing a shared understanding of their difficulties and exploring factors that contributed to challenges.

We met with the art psychotherapist on the day of the visit. We were told that art psychotherapy provided support on a one-to-one and group basis. We heard that the art psychotherapy group was open to all individuals to join and had three aims: supporting individuals with emotional regulation, social interactions, and exploring thoughts and feelings. The art psychotherapist attended the MDT meeting and contributed to care planning and ICP meetings.

We met with OT staff on the day of the visit. We heard that the OT organised weekly skills and social based groups in the ward. We saw a group taking place on the day of the visit, which was well attended.

The OTs also worked with individuals on a one-to-one basis. We heard that the OT completed an initial assessment which included encouraging the individual to complete an interest check list to support care planning and interventions ensuring activities were person-centred and based around the individual's interests to support recovery-based care. The outcome of the initial assessment informed what, if any, other assessments were required. We noted that various assessments such as

assessment of motor and process skills (AMPS) and functional assessments had been completed. The OT staff attended the MDT and ICP meetings.

The ward MDT meeting took place weekly with individuals being discussed on a fortnightly basis. Individuals and relatives/carers were invited to attend. We heard and saw that both individuals and carers regularly attended the MDT meeting and found it a positive experience.

We found detailed recording of the MDT discussion, decisions and personalised care planning. We were pleased to see clear links between MDT discussion, the ICP and care plan outcomes. It was clear that everyone in the MDT was fully involved in the care of the individuals in Craiglea Ward and committed to adopting a holistic approach to care and treatment.

Use of mental health and incapacity legislation

On the day of the visit, 12 people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

All documentation relating to the Mental Health Act and the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), including certificates around capacity to consent to treatment were stored on TrakCare and easily located.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required, including where electroconvulsive therapy (ECT) was being authorised and corresponded to the medication being prescribed.

The hospital electronic prescribing and medicines administration (HEPMA) system was used on the ward. We were pleased to see that individual HEPMA records had an added note when there was a T2 or T3 certificate in place. Although not an automatic alert, each note (embedded in the individual HEPMA record) highlighted that “no other psychoactive medication could be prescribed, unless in an emergency and on discussion with a senior doctor”, as well as stating when the authority to treat was due to expire, and that a copy of the certificate was held on the person’s electronic TrakCare record. On cross-checking the electronic records for everybody, the responsible medical officer (RMO) had completed either a T2 or T3 certificate for 12 individuals in Craiglea Ward. We reviewed the prescribing for all individuals on the ward and found two instances where a prescribed medication was not properly authorised by the T3 certificate in place. We highlighted these errors to the service on the day of the visit, and the issues were resolved by the clinical team.

We suggested that consent to treatment forms should be embedded into the MDT meeting template to ensure they were regularly reviewed and maintained in line with statutory requirements.

We noted the widespread prescribing of vitamin D supplements in the unit. Although this practice was not universal across mental health wards we visit, it reflected broader public health advice issued by Public Health Scotland Vitamin D and you and current national guidance for adults in care homes.

Anybody who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a named person had been nominated, we found this stored on TrakCare and easily located.

For those people that were subject to either power of attorney or guardianship under the AWI Act, we found copies of the order and powers granted recorded on TrakCare and were able to see that there was regular communication with the welfare proxies.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

We reviewed all section 47 certificates and treatment plans and found them to be completed appropriately. We highlighted that some of the treatment plans could have been more person-centred and discussed with the service that any welfare proxies should be clearly recorded and appropriately consulted in relation to decisions about medical treatment.

Rights and restrictions

Craiglea Ward continued to operate a locked door, commensurate with the level of risk identified with those in the ward.

The individuals we met with during our visit generally had a good understanding of their rights and detained status, where they were subject to detention under the Mental Health Act.

All of those we met with were aware of their right to advocacy support and many had active advocacy involvement, provided by the local mental health advocacy service, AdvoCard. Some individuals had legal representation and had been supported to exercise their rights by appealing their detention. For individuals who were assessed as not being able to instruct a solicitor, we saw that a curator ad litem had been appointed to safeguard their interests in the proceedings before the Mental Health Tribunal for Scotland.

We were pleased to see that information on rights was promoted in a variety of ways in Craiglea Ward, including information displayed in the ward, discussions on rights taking place during ICP meetings and one-to-one interventions with staff. We heard that a welfare rights officer had attended the ward to offer guidance on recent benefit changes and to advise on the support available to individuals.

The section in the care plans on legislation supported rights-based care and outcomes. We saw that the legal status of everyone was clearly documented, including reference to any legal authority for financial management, such as corporate appointeeship and the scheduled review dates for these arrangements.

The Royal Edinburgh Hospital (REH) has a patient council group that offers collective advocacy and drop-in sessions that some of those in Craiglea Ward attended.

We were told that the service was trialling a range of approaches to gather feedback from individuals, with the aim of supporting ongoing improvement. A suggestion box and feedback forms was available for individuals to complete. The forms were regularly reviewed by the SCN. In addition, the ward held a weekly coffee morning, which provided an informal opportunity for individuals to share their views and suggestions about the service.

Sections 281 to 286 of the Mental Health Act provide a framework with which restrictions can be placed on people who are detained in hospital. Where an individual is 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.

Three individuals were subject to specified person legislation on the day of the visit. We were able to locate the documentation and reasoned opinions authorising the restrictions. We were satisfied that the restrictions were proportionate to the assessed risk, the least restrictive principle had been applied, and the individual was informed of the restrictions during regular review and made aware of their rights.

We noted that the specified persons documentation was due to expire for all three individuals. We raised this with SCN who advised that arrangements had been made to review the documentation. We discussed the importance of regular review of any restrictions in place.

The Commission has produced good practice guidance on specified persons[1]

When we are reviewing care records, we look for copies of advance statements. The term 'advance statement' refers to written statements made under s275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions

[1] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512

on the treatments they want or do not want. Health boards have a responsibility to promote advance statements.

On the day of the visit one person had an advance statement in place. Most of the individuals we met with were aware of advance statements and had chosen not to complete one. We saw that there was regular discussion regarding advance statements during the ICP meetings. It was evident during review of the care records and during discussion with some of the individuals that they were not at a point in their recovery to be able to make decisions regarding their future care and treatment.

The Commission has developed *Rights in Mind.*[2] 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 heard and found evidence of a broad range of activities available for individuals in Craiglea Ward. The activity and occupation in the ward was provided by OTs, nursing staff and volunteers.

The individuals we met with spoke very positively and were complimentary about the activities offered in the ward and in the community. We heard the activities were person-centred and related to individuals' interests. We heard that one individual had their own therapet which they found very supportive and beneficial to their recovery.

There was an activities board located in the ward that provided information on activities on offer. The activities available included mindful movement, craft group, library sessions, T-shirt design, yoga, knitting and crochet, coffee morning, smoothie group, pool competition and jewellery group. We saw that volunteers attended the ward and provided therapet sessions and some individuals volunteered in the library.

We were pleased to see that individuals were able to access activities out with the ward; some of these were provided by third sector organisations. These activities included The Hive, where individuals could engage in activities and socialise with others in the hospital. Some individuals attended the Glasshouses for gardening activities, with support provided by the Cyrennians and Artlink.

We also saw and heard that individuals were offered a range of activities to enhance daily living skills and support positive rehabilitation outcomes. Individuals were supported to 'deep clean' their room weekly with the support of the housekeeper, domestic staff and their key nurse. Individuals were supported to launder their own clothes. Many individuals engaged in cooking groups and enjoyed cooking their own meals. We were pleased to hear that most individuals felt the activities helped to

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

develop their skills, independence and autonomy while also contributing positively to their ongoing discharge planning.

The physical environment

Craiglea Ward was located on the second floor of the original part of the REH building. After the move in January 2025, the individuals, relatives and staff that we spoke with agreed that the move had been positive.

The layout of the ward consisted of three single and five double bedrooms. There were shared toilets, showers and one bathroom. We noted that the taps in the toilet areas were not ligature safe. We were told by the SCN that the taps had been included on the ligature inspection schedule.

All of the double rooms had a secure partition between bed spaces, which supported a degree of privacy and dignity for individuals. However, we heard from individuals that they felt they were not afforded the same level of privacy, dignity and safety that a single room would provide and that this was an infringement of their human rights.

We were able to view a single and a double bedroom. Both were personalised and clean. The housekeeper supported individuals daily to tidy and clean their rooms, as well as supporting them with their laundry. The cleanliness of the ward was of a high standard.

We were pleased to see that there had been improvements in the sitting and dining rooms areas. Staff had made commendable efforts to create a bright, spacious and comfortable environment incorporating with soft furnishings, artwork and plants promoting a more homely environment. The corridors displayed many pieces of artwork which made the environment feel welcoming. We were particularly impressed with the autumn display on one of the walls which had been collaboratively created by individuals and staff.

We could see that further decoration and repair was required. The SCN told us that the ward was on a waiting list to be painted and that all necessary repairs had been reported to the REH estates department. We were told that the timescales for completing repairs and redecoration were lengthy and no specific timeframe had been provided for when this work would be completed.

Although we were pleased by the proactive efforts of the staff team to create a better environment for the individuals in Craiglea Ward, it would be preferable that plans for the new build, as part of the REH redevelopment project, were progressed to provide an environment for the individuals that would promote their safety, privacy and dignity. We were concerned that the individuals' rights to privacy and dignity, which is protected by Article 8 of the European Convention on Human Rights, were being compromised due to the current environmental factors.

There was a recommendation in the previous two reports in relation to provision of outdoor space and garden areas for individuals in Craiglea Ward. We were disappointed to see that there had been no progress on implementing this recommendation. Although we recognised the location of Craiglea Ward made it difficult to provide outdoor space, the lack of access to outdoor space continued to concern us and the staff team. We consider it important for individuals to have access to safe outdoor space, especially individuals who are experiencing stress and distress. From conversations with individuals, family and staff, there was a clear view that if individuals had access to garden space during times of stress and distress, it could help manage some behaviours more therapeutically, as opposed to using other interventions, such as medication, to alleviate these behaviours.

Recommendation 1:
Managers must prioritise addressing the outstanding environmental issues in relation to ligature work, decoration and maintenance issues to make the environment more homely, therapeutic and safe.

Recommendation 2:
Managers should consider ways to achieve parity in relation to the ward environment, garden access, privacy and dignity for all individuals in the Royal Edinburgh Hospital.

Any other comments

The feedback from most individuals and relatives spoken with in relation to their experience of care and treatment in Craiglea Ward was positive. We were pleased to hear about the strong leadership in the ward and the clear ethos promoted by the management team, which reflected a commitment to supporting staff to deliver high standards of holistic, strengths-based and recovery-focused care. The MDT evidenced a consistent dedication to providing high-quality, specialist and skilled care, in line with the principles of dignity, respect and recovery-oriented practice.

The Commission has consistently made similar recommendations regarding the environment with Craiglea Ward and the wider rehabilitation services at the REH since 2016. It is of concern that limited progress has been made in addressing these issues, as the current environment does not adequately support rehabilitation-focused interventions or uphold individuals' rights to care in conditions that promote recovery, dignity, and wellbeing. The Commission emphasises that these recommendations are not a reflection on the high standard of care and professionalism demonstrated by staff in Craiglea Ward, but rather on the need for systemic and environmental improvements to support their work.

Summary of recommendations

Recommendation 1:
Managers must prioritise addressing the outstanding environmental issues in relation to ligature work, decoration and maintenance issues to make the environment more homely, therapeutic and safe.

Recommendation 2:
Managers should consider ways to achieve parity in relation to the ward environment, garden access, privacy and dignity for all individuals in the Royal Edinburgh Hospital.

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

Mental Welfare Commission 2025