Mental Welfare Commission for Scotland

Report on announced visit to:
The Royal Edinburgh Hospital, Hermitage Ward, Morningside Place, Edinburgh, EH10 5HP

Date of visit: 17 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

Hermitage Ward is the mixed-sex, adult acute psychiatric ward for individuals primarily residing in East and Mid Lothian areas of NHS Lothian. We heard most of the beds are used by East and Mid Lothian individuals, however some of the beds are occupied by individuals from the City of Edinburgh area for a variety of reasons, including individual preference of not wanting to be admitted to a single-sex ward and/or resulting from risk assessment.

Hermitage Ward has 16 beds, although on the day of the visit there were 17 individuals in the ward, with one individual sleeping in the quiet room. We were told that eight individuals from other adult acute wards in the Royal Edinburgh Hospital (REH) were boarding in Hermitage Ward and that six individuals that met the criteria for Hermitage Ward were boarding in other wards in the REH. We were told that three individuals' discharge was delayed due to them awaiting provision of a specialist service and community care services.

We last visited this service in August 2024 and made recommendations in relation to care planning, consent, and authority to treat certificates, activity provision, and the continued use of the quiet room as a bedroom.

On the day of this visit we wanted to meet with individuals and relatives/carers to hear how care and treatment was being provided on the ward and also follow up on the previous recommendations.

Who we met with

We met with, and reviewed the care of eight people, seven who we met with in person and five who we reviewed the care records of. No relatives wanted to speak or meet with us on the day of the visit. We offered to make contact with relatives/carers following the visit however, no contact was made.

We spoke with the general manager, the deputy chief nurse, the clinical nurse manager, the senior charge nurse (SCN), nursing staff, a psychologist, a music therapist and the recreational nurse.

Prior to the visit, we contacted the mental health officer (MHO) teams from East and Mid Lothian. Following the visit, we contacted City of Edinburgh MHO team, and CAPS and Advocard advocacy services.

Commission visitors

Kathleen Liddell, social work officer

Dr Juliet Brock, medical officer

What people told us and what we found

Comments from individuals

The feedback from individuals we met with on the day of the visit was mixed. We heard that staff were “supportive” and “go above and beyond”. All individuals we met with told us that the ward was understaffed on a regular basis and that staff were always extremely busy. We heard that this had an impact on individuals feeling able to approach staff for one-to-one support.

Most of those that we spoke with told us that they had been provided with a copy of their care plan the night before the Commission visit. We heard from most individuals that they had been unaware of their care plan prior to this and that they were not involved in completing their care plan. We heard from some individuals that they were unaware of discharge planning and that they wanted to be more involved in discussions regarding their future care planning.

Not all individuals felt involved in discussion and decision-making regarding their care and said that they would like the opportunity to have increased participation. We heard from some individuals that they attended the weekly multidisciplinary team (MDT) meeting and felt able to provide their views in relation to their care and treatment.

We also heard from individuals who lived in the City of Edinburgh catchment area that they did not have the same opportunity to attend the MDT meeting and raised concerns that their views were not taken into account during this meeting.

We discussed concerns over a lack of participation with advocacy services. Advocacy services confirmed that there had been a lack of involvement in decision making and this was a common theme raised by individuals they met with in Hermitage Ward.

Given that we continue to hear concerns around meaningful participation in care and treatment, we will repeat our previous recommendation.

Recommendation 1:
Managers must ensure that there is a system in place for all individuals that is understood and offer them an opportunity to engage in meaningful participation in care planning and decisions about their care and treatment. The participation of the individual should be recorded in their clinical record.

Some individuals raised that they felt aspects of their care plan was too restrictive, especially in relation to pass time out of the ward. We reviewed the pass planning and risk assessment of these individuals and found that although the rationale for the restrictions was proportionate, there was a lack of regular review and discussion with the individuals regarding pass planning decisions.

Many of the individuals we met with raised that the ward environment could be "challenging" and "difficult" on occasions. We heard that individuals had witnessed episodes of self-harm and assaults. One individual told us that they had been called "derogatory and homophobic" names which did not make them feel safe. We were told by many individuals that due to staff shortages, they felt that at times "staff did not always have control of the ward", however they did try and support individuals during these more challenging times.

We heard mixed views from individuals about organised activity in the ward. Some individuals told us that they engaged in regular activity that they enjoyed. Others told us that they did not have an interest in the activities offered in the ward and felt "bored". We heard there was a focus on arts-based activity that not all individuals had an interest in and they would prefer it if a wider range of activities was available. We heard from all individuals spoken to that when they did engage in activity they enjoyed, and it benefitted them.

Staff comments

We spoke with various members of the MDT who commented that, in general, they enjoyed their role in the ward. All staff told us that the level of acuity and complexity in the ward had increased. We were told that many individuals required continuous intervention and that bank and agency staff were required to support these interventions. We heard that there was a period where the ward was providing care to 20 individuals in a 16-bedded ward, which was extremely challenging for staff and individuals.

We were pleased to hear that the number of individuals in the ward had reduced and that there was a commitment to discontinuing the use of contingency beds across the REH hospital site.

We heard that there had been staff shortages, which was challenging for the established staff team. We were pleased to hear that there was a core group of experienced staff in Hermitage Ward as well as newly qualified nursing staff. We were concerned to be told that it was common practice for one member of registered nursing staff to be on shift. Less experienced staff told us this could feel overwhelming, especially as individuals in Hermitage Ward often had needs that were complex, combined with high acuity.

The SCN told us about plans to recruit a new Band 6 charge nurse. Once the management team is fully staffed in the ward, a senior member of staff will be available on every shift to offer more direct supervision and support to staff. We were encouraged to hear that the ward expected to have its full staffing in place imminently, which should help reduce pressures on the team.

Care, treatment, support, and participation

We were told and saw that NHS Lothian had implemented a new person-centred care plan on 30 April 2025. 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 SCN told us that the introduction of the new care plans took place at a particularly challenging time for the ward. We heard that all individuals had a person-centred care plan in place however, not all sections had been completed due to staff shortages and the high level of acuity that staff had to respond to. We were concerned to hear this, as comprehensive care planning is essential in directing the care, treatment and interventions necessary to support individuals with acute and complex mental health needs. The SCN told us that a plan had been developed to support the completion of care plans. We were also told that the ward anticipated being fully staffed in the near future, which would allow staff the necessary time to dedicate to the completion of care plans, with further support available from clinical educators.

We found the care plans in Hermitage Ward to be of mixed quality. We saw some good 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 outcomes.

However, the majority of care plans we reviewed lacked detail, making it difficult to ascertain the individuals' goals, the specific aims of the admission and what interventions were required by the MDT to support the care and treatment required to promote recovery and discharge.

There was a lack of participation from the individuals in their care planning which reflected the feedback from those spoken with. The care plans we reviewed did not reflect a person-centred approach to care. We discussed with the service that we would expect all sections of the person-centred care plans to be completed, with a particular focus on the 'what matters to me' section, to ensure meaningful involvement of individuals in their care planning.

We saw that there were three individuals whose discharge was delayed. We found that for some of these individuals, there was no discharge care plan in place and no evidence of regular MDT discussion regarding discharge planning. We would expect that for individuals whose discharge is delayed, a comprehensive discharge care plan is completed and regularly reviewed by the MDT to ensure that all barriers to discharge are clearly identified, actively monitored and addressed in a timely manner.

We were unable to find regular review of the care plans. Care plan reviews are essential for evaluating progress, updating goals and ensuring that interventions remain appropriate, effective and align with the individual's current needs.

Recommendation 2:
Managers must ensure nursing care plans are person-centred, contain individualised information reflecting the care needs of each person, identify clear interventions and care goals, include a summative evaluation indicating the effectiveness the interventions being carried out, any changes required to meet care goals, and are regularly reviewed.

From review of the care records, we found that some of the individuals in Hermitage Ward had physical health care needs. We were pleased to find that there was a focus on physical health care, with evidence of physical health care needs being addressed and followed up by medical staff.

We found risk assessments in Hermitage Ward to be of mixed quality. We saw one risk assessment which was of a high standard and included a chronology of risk, triggers, stressors, protective factors, along with a risk management plan with clear strategies to manage the assessed risks. However, other risk assessments lacked detail and did not reflect the current risks for individuals that were documented elsewhere in the care records. We highlighted one issue to the service on the day of the visit where essential information relating to increased risk had not been included in an individual's risk assessment. We were concerned that this omission posed a potential risk to the safe delivery of care and the ability of staff to implement appropriate risk management strategies.

Recommendation 3:
Managers should ensure that all risk assessments provide clear and comprehensive information on current risks, are supported by a detailed risk management plan and are reviewed regularly to ensure they remain accurate and reflective of the individuals' needs.

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.

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

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 review of the care records, we saw that individuals in Hermitage Ward had complex and acute mental health needs and required high levels of staff support and intervention.

We found the information recorded was mainly comprehensive, individualised with information being recorded by all members of the MDT. 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.

We were pleased to see regular senior medical reviews of individuals recorded in the care records. The information reviewed was comprehensive and included the views of the individual, an assessment of the individual's presentation and a plan detailing required interventions and follow-up.

Although the individuals we met with told us they did not have regular one-to-one discussions with nursing staff, when reviewing the care records, we were able to see regular one-to-one interactions being offered and provided. Most of the one-to-one care records reviewed were comprehensive, personalised and strengths-based. We saw positive and regular examples of staff having discussions with individuals exploring views on their care plan and any issues of concern.

We found that the care records included some examples of communication with families.

Multidisciplinary team (MDT)
The unit had a broad range of disciplines either based in Hermitage Ward or accessible to them.

In addition to nursing staff, there were consultant psychiatrists, psychology, occupational therapy (OT), a recreational nurse, junior doctor and a music therapist. The structure of the MDT in Hermitage Ward differed from the other acute wards in the REH, as it covered two health and social care partnerships (HSCPs) as well as the City of Edinburgh area.

We met with the psychologist on the day of the visit. We were told that one of the core roles of psychology in Hermitage Ward was to support the MDT. Psychology provided fortnightly reflective practice sessions to the MDT and one-to-one staff support when required. We were told that there was no psychological group work available in the ward. We heard from individuals and staff that the individuals in

Hermitage Ward would benefit from support with emotional regulation and that structured psychological group interventions could help address this need.

We heard that psychology provided assessment of individuals from Mid and East Lothian and completed a risk formulation. We also heard that psychology based in Hermitage Ward did not always have capacity to provide input for individuals from City of Edinburgh. If psychology was required for City of Edinburgh individuals, referrals were made to the psychologist associated with the individuals' catchment area. We also heard that when individuals from Mid and East Lothian were boarding in other wards in the REH and required psychological input, this was not always able to be provided by the ward-based psychologist. The psychologist acknowledged that the current arrangement was not ideal and that it did not support consistent or equitable access to psychological interventions. We were concerned that this fragmented approach did not fully align with a cohesive MDT model, in which regular and co-ordinated psychological input is integral to delivering holistic care.

Recommendation 4:
Managers should review access to psychological therapies for all individuals in Hermitage Ward, including those boarding elsewhere to ensure parity and equity of service.

We met with the music therapist on the day of the visit. We heard that music therapy was offered on a one-to-one and group basis on the ward and that all individuals could access this. We heard that music therapy was a safe space to support engagement and social connection, contributing to a recovery-focused approach to care. The music therapist contributed to the person-centred care plans and MDT meetings.

We contacted all three local authority MHO teams. We were told that, in general, there were good working relationships with the MDT in Hermitage Ward. One MHO team raised concerns about the communication of care plan decisions for individuals who were boarding in other acute wards in the REH. We heard that this was especially problematic when decisions were being made about individuals detained status, and that on occasion, orders had been revoked and individuals discharged without any discussion with social work. Concerns were also raised about social work not always being involved in discharge planning. There was a view from social work that a more inclusive and collaborative approach to discharge would better support the individual.

Mid and East Lothian consultant psychiatrists held weekly MDT meetings on the ward. The MDT meeting for East and Mid Lothian individuals was recorded on TRAKCare. The MDT meetings we reviewed were recorded on a mental health structured MDT meeting template; the template had headings relevant to the care and treatment being offered in the ward. We found that these records were

comprehensive and contained detailed recording of the MDT discussion and decisions. We were pleased to find that some individuals had attended the MDT meeting and provided their views on various aspects of their care and treatment.

In our previous report, we raised concerns that individuals boarding in Hermitage Ward did not have access to consistent weekly MDT meetings and were instead reviewed solely by their consultant psychiatrist on a weekly basis, without MDT input or involvement of the individual. We were told that the service would review this arrangement and consider alternatives to support a full MDT approach to discussion and decision-making for all individuals in Hermitage Ward.

We were disappointed to find that there had been no progress or changes to this arrangement and that unilateral decisions continued to be made by the consultant psychiatrist, which did not support an MDT or holistic approach to care and treatment. We heard from many individuals from the City of Edinburgh that they did not attend an MDT meeting and were unaware of decisions being made about their care and treatment.

Members of the MDT also reported that although multiple discussions took place between disciplines, there was no formal opportunity to meet as an MDT to discuss individuals' care. We discussed with the senior management team the lack of parity for individuals boarding in Hermitage Ward and were advised that an urgent review of these arrangements was required to ensure a full MDT approach to discussion and decision-making for all individuals.

Recommendation 5:
Managers should urgently review current arrangements to ensure all individuals in Hermitage Ward receive regular MDT review with full multidisciplinary input and active involvement of the individual.

Use of mental health and incapacity legislation

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

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.

The hospital electronic prescribing and medication administration (HEPMA) system was used on the ward and we reviewed the prescribing for all individuals. We found that one person who was no longer subject to the Mental Health Act was prescribed injectable as required medication. The Commission views that intra-muscular (IM) medication for acute agitation should not be prescribed to individuals who are admitted informally. We also found variability in prescribing practice in relation to

medication prescribed for rapid tranquilisation. We raised this with the associate medical director following the visit, to help identify any training needs for junior medical staff in this regard.

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 ECT was being authorised. We found that one person had recently been prescribed a medication which was not authorised by their T3. Again, this was raised with senior staff following the visit to ensure this was rectified.

In another case we questioned whether an individual (who was informal) was giving informed consent for depot medication, a treatment with which they disagreed. We asked that their consultant psychiatrist review the situation and consider whether treatment under the Act was required.

We suggested that authority for treatment should be embedded into to the MDT structured ward round template to ensure that T2 and T3 forms are regularly reviewed and maintained in line with statutory requirements.

Recommendation 6:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, and that all psychotropic medication is legally authorised.

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 easily located on TRAKCare.

We saw that for one individual we met with and whose records we reviewed, there was evidence of them being subjected to physical harm in Hermitage Ward. We were concerned that no datix (the local incident reporting system) had been completed, that police involvement had not been considered or discussed with the individual, and that the incident had not been reported in accordance with the Adult Support and Protection (Scotland) Act, 2007 or local adult support and protection procedures. We raised this matter with the SCN on the day of the visit.

We were concerned at the lack of knowledge that staff had regarding safeguarding legislation, its application and the current NHS Lothian adult support and protection procedures published in 2025. We advised the SCN that the matter should be reported to the local social work department urgently for the concerns to be assessed and managed in line with statutory responsibilities.

Recommendation 7:
Managers must ensure that all staff understand and follow the Adult Support and Protection (Scotland) Act 2007 and local procedures. Staff must recognise, record, and report all incidents of potential harm promptly and in line with statutory requirements, with appropriate training and managerial support provided to ensure compliance.

Rights and restrictions

Hermitage Ward continued to operate a locked door, commensurate with the level of risk identified with the individuals in the ward. The locked door policy was displayed at the entrance door.

We noted that there was a range of information on rights displayed and available to individuals in Hermitage Ward. In particular, we found the information board displayed at the entrance of the ward provided good information on the Mental Health Act, criteria for various mental health orders, individuals' rights when subject to orders, and how to exercise their rights.

As well as written information, the information board included QR codes to the Commission's website, to support the individual accessing further rights-based information.

Most of the individuals we met with were aware of their rights, had access to either advocacy and/or legal representation and had been supported to exercise their rights by appealing their detention.

We contacted CAPS and Advocard services and both reported that during their contact with individuals in Hermitage Ward, there was a theme of individuals raising that they did not feel listened to or involved in decisions regarding their care and treatment. We were encouraged to hear that advocacy services continued to provide ongoing independent support aimed at promoting individuals' rights and participation in their care.

The new person-centred care plan included a section on legislation. Some of the legislation care plans recorded that rights had been discussed with the individual, which supported a rights-based approach to care and outcomes. However, we were disappointed that not all legislation care plans contained this level of detail and it was evident from our discussions with individuals that they felt they would benefit from more regular discussion regarding rights and how to exercise them as due to their illness, they were not always able to retain this information.

The ward held a weekly coffee morning, which provided an informal opportunity for individuals to share their views and suggestions about the service.

Two individuals were subject to continuous intervention (CI) on the day of the visit. Both individuals had a CI care plan in place. On review of these plans, we were able to see that the use of CI was proportionate to the identified risks. However, we would expect the CI care plans to include more detailed information on the specific risks being addressed, the MDT interventions required, and clearer reflection of the individuals' views and preferences. We raised this with the senior management team on the day of the visit who acknowledged that further improvements to care planning was required. We will monitor the service improvement plan during future visits.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where an individual is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied.

We were told that one individual was 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 and made aware of their rights. However, we noted that the specified persons documentation for the individual had expired. We raised this with SCN who advised that an urgent review would be arranged. We discussed the importance of regular review of any restrictions in place, and the individual should be made aware of this lapse and of their rights around this.

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

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

There were no advance statements in place on the day of the visit. Some of the individuals we met were aware of advance statements and had chosen not to complete one, while others were unaware of advance statements. We discussed the use of advance statements with advocacy services, who informed us that individuals receiving advocacy input were given information about advance statements and offered support to complete one if they wish. We heard that most individuals chose not to complete one. It was evident from our review of care records and from

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

discussions with some individuals that they were not at a point in their recovery where they felt able to make decisions regarding their future care and treatment.

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 heard and found evidence of a range of activities available for individuals in Hermitage Ward. The activity and occupation in the ward was provided by the recreational nurse, OTs and volunteers.

The individuals we met with provided mixed views regarding the activities available in Hermitage Ward. Some individuals told us that they enjoyed the activities offered, while others reported that although some planned activities did take place, they did not always meet their personal interests or occupational goals and were therefore not fully person-centred. All individuals, however, emphasised that engagement in meaningful activity contributed positively to their recovery and well-being

We met with the recreational nurse on the day of the visit who recognised that many of the activities available were arts-based and that not all individuals engaged with or enjoyed these activities. We were encouraged to be told that the recreational nurse had a plan to meet with everyone on the ward to discuss activity interests, goals and outcomes and would record this information in the care plan.

There was an activities board located in the ward that provided information on activities on offer. The activities available included scrapbook group, knitting and crochet, creative sessions, fitness club, music session, outdoor activity and mindful meditation. We saw that a volunteer attended the ward and provided a therapet session.

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.

The physical environment

Hermitage Ward is the only mixed-sex admission ward in the REH, therefore the physical environment must be managed differently from other admission wards in the hospital, to ensure individuals feel safe and comfortable in the ward setting.

The bedroom zones in the ward were divided into a male and female area. Each bedroom has en-suite facilities, and we were aware that individuals could

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

personalise their bedroom if they chose to. Some individuals raised that the ward was cold, especially at night. We raised this with the senior management team on the day of the visit who agreed to explore this matter with individuals.

The main space used by individuals and staff was an open plan, communal TV/dining area. On the day of the visit, we saw individuals and staff congregate in this area, engaging in conversation and activity. We were told by some individuals that this area could get busy and loud, and that quieter spaces were difficult to access. There was a female quiet room available to use however, there were no chairs in the room. We discussed with the SCN the importance of creating additional therapeutic spaces for individuals, and it was agreed that staff would prioritise placing chairs in this room.

The cleanliness of the ward was of a good standard. We were pleased to see and hear that the ward had been painted since the previous visit and that new, more comfortable chairs had been purchased for the communal area. Some areas of the environment continued to feel clinical and would benefit from some artwork to create a more therapeutic and homely environment. We were encouraged to hear from the SCN that artwork had been ordered for the ward and it was expected to be placed in the ward imminently.

In our previous report, we made a recommendation in relation to concerns over the use of one of the quiet rooms in the ward. A 'contingency bed' was being kept in the male quiet room which was being used as a bedroom. We were disappointed to hear that the quiet room had continued to be used regularly as a bedroom since our last two visits, and we observed this again on the day of the visit.

We raised our concerns with the senior management team regarding the lack of washing or toilet facilities, the evident ligature risks, and the compromise to the individual's right to privacy and dignity. We were told that individuals placed in the contingency bed were subject to CI while in the room, and that this decision had been made by senior NHS Lothian managers. While we recognise that this intervention supports the management of risk, we were concerned that it is restrictive, constitutes a deprivation of liberty and is only necessary due to a lack of appropriate bed provision.

The senior management team advised that reducing the use of contingency beds across the REH hospital site had been a priority and that many contingency beds had been closed. We were encouraged to hear this; however, we remain concerned that contingency beds continue to be used in circumstances that compromise individuals' privacy, dignity, and rights and are therefore repeating this recommendation once again.

Recommendation 8:
Managers must consider the benefits of returning the dedicated quiet room in the ward to provide a therapeutic and quiet space for individuals and staff and ensure that all individuals admitted to the ward are provided with a dedicated bedroom.

There was a large courtyard garden area that was easy for individuals to access. We were told that individuals could access the garden area from 6am until midnight. We saw during the visit that this area of the ward was regularly used by individuals.

We were pleased to see and hear that the ward had implemented current Scottish Government legislation prohibiting smoking in hospital grounds.

Any other comments

The feedback from individuals regarding their care and treatment in Hermitage Ward was mixed. We were concerned to hear and observe a recurring theme of individuals not being involved in discussions or decisions relating to their care and treatment.

The Mental Health Act sets out the principle of participation, which requires that individuals are fully involved in all decisions affecting them, as far as is practicably possible. This principle places a clear duty on health boards to ensure that individuals are provided with meaningful opportunities to express their views, given information in a way they can understand, and supported to have those views considered when care and treatment decisions are made. We would expect NHS Lothian to ensure that all individuals in Hermitage Ward are enabled and supported to participate actively in their care, as this is essential to upholding rights-based practice and delivering recovery-focused, person-centred treatment.

During the visit, we observed that the level of acuity in the ward was high and that the individuals' needs were complex, requiring staff to provide intensive interventions and support. We were encouraged to hear that reflective practice was provided by psychology to support staff in managing these challenges. We also heard that there was a gap in the ward management team and that it was hoped the management team would be at full complement imminently to offer more regular and direct supervision to staff. It is essential that staff are supported appropriately to carry out their roles safely and effectively.

Summary of recommendations

Recommendation 1:
Managers must ensure that there is a system in place for all individuals that is understood and offer them an opportunity to engage in meaningful participation in care planning and decisions about their care and treatment. The participation of the individual should be recorded in their clinical record.

Recommendation 2:
Managers must ensure nursing care plans are person-centred, contain individualised information reflecting the care needs of each person, identify clear interventions and care goals, include a summative evaluation indicating the effectiveness the interventions being carried out, any changes required to meet care goals, and are regularly reviewed.

Recommendation 3:
Managers should ensure that all risk assessments provide clear and comprehensive information on current risks, are supported by a detailed risk management plan and are reviewed regularly to ensure they remain accurate and reflective of the individual's needs.

Recommendation 4:
Managers should review access to psychological therapies for all individuals in Hermitage Ward, including those boarding elsewhere to ensure parity and equity of service.

Recommendation 5:
Managers should urgently review current arrangements to ensure all individuals in Hermitage Ward receive regular MDT review with full multidisciplinary input and active involvement of the individual.

Recommendation 6:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, and that all psychotropic medication is legally authorised.

Recommendation 7:
Managers must ensure that all staff understand and follow the Adult Support and Protection (Scotland) Act 2007 and local procedures. Staff must recognise, record, and report all incidents of potential harm promptly and in line with statutory requirements, with appropriate training and managerial support provided to ensure compliance.

Recommendation 8:
Managers must consider the benefits of returning the dedicated quiet room in the ward to provide a therapeutic and quiet space for individuals and staff and ensure that all individuals admitted to the ward are provided with a dedicated bedroom.

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

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