Mental Welfare Commission for Scotland

Report on unannounced visit to:
Findlay Community Hospital, Ward 1, 5 Seafield Street, Edinburgh, EH6 7LN

Date of visit: 23 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

Ward 1, formerly known as Prospect Bank Ward is based in Findlay Community Hospital, and is a hospital-based complex continuing care (HBCCC) unit providing care for older adults with complex needs and a diagnosis of dementia.

Ward 1 is one of two NHS wards that compromise Findlay Community Hospital, a single-story unit based on the former Eastern Hospital site. The building is owned and managed by a private company as part of a private finance initiative (PFI), with meals, laundry and domestic services provided by NHS Lothian.

Following ward closures in another hospital site in Edinburgh, nursing staff had transferred to Findlay Community Hospital.

On the day of the visit, there were 21 people on the ward, 20 of whom were male with one female. The ward-based team were in the process of planning discharge for the last female patient.

When we last visited the service, we made two recommendations in relation to improvements around the recording of discussions and actions from multidisciplinary team (MDT) meetings. We also made a recommendation to ensure individuals who were admitted to the ward had access to advocacy services.

We were informed both recommendations had been actioned and that discussions and decisions from MDT meetings were documented in individuals' care records. We were also told that advocacy services were now available for all individuals and their carers, with information provided by mental health officers and ward-based staff.

The visit to Ward 1 was unannounced, which provided an opportunity to consider day-to-day activity on the ward and how nursing staff undertook their duties and responsibilities.

Who we met with

Due to the level of cognitive impairment, we were unable to meet with individuals to ask their views about the care they had received; however, we were pleased to have the opportunity to meet with relatives who were regular visitors to the ward.

We reviewed the care of five people in addition to speaking with nursing staff and reviewing their care. We also met four relatives.

We spoke with the service manager and the senior charge nurse (SCN) following the visit. We were supported throughout the day by senior staff on duty and members of the quality improvement team.

Commission visitors

Anne Buchanan, nursing officer
Tracey Ferguson, social work officer

What people told us and what we found

On the day of this unannounced visit, we saw interactions between staff and individuals that were warm, compassionate and good humoured. While several individuals required to be supported and cared for in their bedrooms, the team ensured people were provided with opportunities to spend time with them to reduce the risk of social isolation.

Nursing staff were present throughout all communal areas of the ward, and we were told nursing staff positively encouraged relatives to participate in mealtimes and social engagement.

We were able to observe and sit alongside several individuals and listen to interactions between them and the nursing team. We saw interactions where individuals were encouraged to engage in social connections through activities. Individuals who by virtue of their significant cognitive impairment required enhanced support however, this did not appear intrusive and allowed individuals to explore their environment safely.

We heard from relatives about their own positive experiences and that communication was considered important; relatives felt very involved in care and treatment reviews, with their opinions sought throughout their relative's admission. We were told by relatives that continuing to provide a degree of care for their own relative was important to them and they valued the opportunities to support mealtimes and one-to-one activities. Having opportunities to share experiences with fellow carers and relatives was important and getting to know each other was seen as valuable, as a form of informal peer support. While most relatives spoke positively about their own experiences, there were some concerns raised in relation to communication with medical staff, and at times relatives felt they were not always given access to current information.

Care, treatment, support, and participation

Individuals' care records were held electronically on TRAKCare, which we found easy to navigate.

We were informed there had been a development in terms of care planning with an improved electronic template now in place. While the new template was in its infancy, we could see there were areas of focus directly relevant to individuals who by virtue of their diagnosis and cognitive impairment required an enhanced level of support. The ward also had a separate folder for each individual, containing paper copies of relevant legal documentation, including certificates authorising treatment under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act), which are also available electronically, the Adults with Incapacity

(Scotland) Act, 2000 (the AWI Act), and 'getting to know me' forms, which are usually completed by relatives to support person-centred care planning.

For individuals who required care plans that were specifically put in place to focus upon stress and distress or behaviours often associated with a dementia diagnosis, those care plans were detailed and provided an understanding of an individual's presentation, as well as triggers that had the potential to cause distress and how staff could support the individual through a calm and compassionate response. We were told nursing staff had received training for supporting individuals who presented with stress and distress in the context of a dementia diagnosis. For new staff to the ward, we were told of plans for those who were awaiting training, although they had felt very supported by the ward-based team and their skills had improved through their guidance and support. While we were able to review the care plans, we would suggest that also having copies held electronically on TRAKCare would be beneficial.

We were pleased to have found physical health care was deemed a priority for individuals admitted to Ward 1. The team recognised individuals living with dementia and significant cognitive impairment were by and large unable to verbally express their pain or discomfort. We were told by relatives that the nursing and medical team were very attentive and intuitive to understanding each individual and their unique presentations that may indicate when an individual was experiencing discomfort and managing this promptly and appropriately.

Physical care and monitoring was undertaken regularly and any referral that required specialist medical attention was made without delay. The ward benefitted from having access to an advanced nurse practitioner (ANP) who had advanced clinical training that enabled them to assess and manage people's health conditions.

Care records

We had the opportunity to meet with the service-based quality improvement (QI) team who had been supporting Ward 1 staff. QI specifically in relation to dementia care in hospital settings has been considered invaluable to promoting person-centred care, improving safety and supporting nursing staff's professional development. The QI team had several areas of focus and had provided an oversight programme to ensure care and treatment was person centred, undertook regular audits, shared outcomes with the team and implemented improvement plans where necessary.

Of the care plans we reviewed, there was a degree of variation between them. We reviewed care plans that were very detailed and provided the reader with an opportunity to fully understand the complexities of an individual's presentation and their needs. However, this level of detail was not consistent in other care plans we reviewed. Where stress and distress had been evident for individuals admitted to

Ward 1, we found care plans that would be considered person-centred and had input from relatives. We would like to have seen a greater understanding of where relatives had input into all care planning. The reason for this was the number of relatives who visited their family member in the ward and provided daily support for their relative. The inclusion of those activities would have demonstrated a shared model of collaborative care that valued the input of relatives.

We were informed that care plan reviews formed part of the QI programme; however, it was not always clearly documented when these reviews had been undertaken or whether any amendments to care and treatment were required. We were informed that daily progress notes should align with individuals' care plans; however, this correlation was not always evident. On review, there appeared to be a lack of clear linkage between daily entries and care plan objectives, which made it difficult to gain a comprehensive understanding of specific areas where enhanced staff support was required.

Recommendation 1:
Managers should review existing care plans and the current framework for documenting daily progress notes to assess whether the system offers best practice for capturing information.

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.

Multidisciplinary team (MDT)
Individuals admitted to Ward 1 had a consultant psychiatrist overseeing their medical input during their admission. The ANP and clinical fellows covering the hospital (supervised by an associate specialist in geriatric medicine) also provided input in relation to the physical health needs of individuals. Access to physiotherapy, speech and language therapy and dietetics was through referral. We were told referrals were accepted and actioned without issue. Furthermore, the ward had a mix of skilled nursing staff who were registered mental health and registered general nurses. The MDT met weekly to discuss every individual. In addition, to this weekly meeting there were three-monthly reviews, in which relatives were included, that provided a more in-depth discussion, including of ongoing eligibility for HBCCC. We would expect to locate a detailed record of weekly MDT meetings, including a record of who attended those meetings, any actions required and outcomes. We would also have expected to find discussions in relation to future planning particularly where there may have been a deterioration in an individual's presentation. Following our last visit to Ward 1 we made a recommendation in relation to recording of discussions from MDT meetings, and that those recordings should be evidenced in

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

individual's electronic care records. While we were able to locate evidence of the weekly MDT meeting, information about any discussion was lacking and did not offer the reader a sense of depth to discussions, actions or outcomes.

Recommendation 2:
Managers, including senior medical staff should ensure that MDT weekly meetings are recorded accurately, while providing evidence of discussions, outcomes and any necessary actions.

Use of mental health and incapacity legislation

On the day of the visit, 10 people were detained under the Mental Health Act. The ward kept a folder with copies of legal documents for all individuals. We thought this was useful however, during our review of Part 16 of the Mental Health Act which sets out the conditions under which treatment may be given to those individuals who are detained and, who are either capable or incapable of consenting to specific treatments, we found several certificates missing from prescription charts.

We would expect copies of treatment certificates to be available to support nurses when dispensing treatment to individuals. We would propose there should be copies of certificates authorising treatment (T3 certificates) kept with all prescription charts and nursing staff should ensure that where there have been any amendments to T3 certificates, there are up to date copies stored appropriately.

When we were able to locate electronic certificates authorising treatment under the Mental Health Act, they were in place where required and corresponded to the medication being prescribed.

For those people who were receiving care under the AWI Act, we found their paperwork stored in paper copy and in their electronic records.

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. Of the section 47 certificates we reviewed we saw several that had been recorded with an accompanying treatment plan however, not all certificates demonstrated that the legal proxy decision maker had been consulted. As previously stated, this is a legal requirement.

Recommendation 3:
Managers and medical staff should ensure appointed legal proxy decision makers are consulted and this is recorded in each section 47 certificate completed.

For individuals who had covert medication in place, not all appropriate documentation was in order, as most had no recording of reviews or the pathway where covert medication was considered appropriate. The Commission has produced good practice guidance on the use of covert medication.[2]

Recommendation 4:
Managers and medical staff should ensure where an individual requires medication to be administered covertly that regular reviews are undertaken and recorded appropriately.

Rights and restrictions

Ward 1 continued to operate a locked door, commensurate with the level of risk for individuals in the ward; there was a locked door policy in place to support this.

We were told independent advocacy service offered support and engagement with individuals admitted to the ward. We had made a recommendation following our last visit in relation to individuals' access to advocacy services, therefore we were satisfied this recommendation had been actioned.

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

On the day of the visit, we had the opportunity to meet with the activities coordinator who was keen to ensure all individuals had opportunities for social connections or one-to-one engagement. We were pleased to see, during our review of care records, that the activities coordinator regularly visited individuals in their bedrooms, particularly those individuals who had lost mobility and required care in bed.

Support during mealtimes was also seen as an activity that could be shared and gave an opportunity for shared connection, conversation and relaxation. While there was a programme in place that provided information on daily activities available, there was also a sense that for some people, having a bespoke programme was better suited to their abilities on any given day.

Volunteers regularly visited individuals in the ward, and we were told that both the ward-based team and individuals valued their input as it offered friendships and social connections.

[2] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492
[3] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

The physical environment

The ward environment was light, bright and very clean. The ward was mostly well maintained, with the exception of a few well-used areas that could have benefitted from being refreshed and re-painted. The ward benefited from several communal areas and a dining room. While the dining room was not large enough to accommodate all individuals, it was also recognised having separate spaces for mealtimes reduced potential triggers for people and allowed them to have relaxed mealtimes.

There was a large sitting room that was also used for activities, and with regular themes, including sporting occasions or seasonal themes. The space was decorated to help individuals appreciate the time of year and important events in the calendar.

The ward consisted of three corridors radiating from the central atrium. The atrium remained a popular place for individuals to sit and spend time with each other.

Bedrooms were personalised with pictures and personal items and individuals were encouraged to bring their own bedding, for example soft, sensory throws to help reduce anxiety at nighttime. Each bedroom had en-suite facilities and an accessible shared bathroom provided for each corridor.

The large, enclosed garden provided an inviting outdoor space for individuals and their relatives to enjoy. Individuals had to be accompanied in the garden to reduce the risk from falls, nevertheless, staff were keen for everyone to have access to the outdoors and fresh air whatever the season. The garden was well maintained with planting, seating areas and a covered gazebo.

Any other comments

Ward 1 admitted individuals, who by virtue of their diagnosis and significant cognitive impairment, required hospital-based care. We heard from relatives how they valued the compassionate person-centred care their family member had received. While it was clear there were occasions when staff experienced many competing demands, their commitment to provide care that was bespoke to the needs of individuals was unwavering. We look forward to our future visit to Ward 1 and having further opportunities to meet with individuals, their relatives and the team.

Summary of recommendations

Recommendation 1:
Managers should review existing care plans and the current framework for documenting daily progress notes to assess whether the system offers best practice for capturing information.

Recommendation 2:
Managers, including senior medical staff should ensure that MDT weekly meetings are recorded accurately, while providing evidence of discussions, outcomes and any necessary actions.

Recommendation 3:
Managers and medical staff should ensure appointed legal proxy decision makers are consulted and this is recorded in each section 47 certificate completed.

Recommendation 4:
Managers and medical staff should ensure where an individual requires medication to be administered covertly that regular reviews are undertaken and recorded appropriately.

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.

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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