

## **Mental Welfare Commission for Scotland**

### **Report on announced visit to:**

Royal Edinburgh Hospital, Islay Centre and Carnethy House,  
Edinburgh, EH10 5HF

**Date of visit:** 3 February 2026

**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**

The Islay Centre comprises of three units, with a total of 11 individualised areas that combine day/sleeping areas. In addition to this unit, Carnethy House provides a service for one other individual. Both units are based in the grounds of the Royal Edinburgh Hospital (REH).

This service provides assessment and treatment for individuals with a learning disability, who have complex and challenging behaviours, often associated with a diagnosis of autistic spectrum disorder.

On the day of our visit, both units were at capacity.

We last visited this service in August 2024 as an announced visit and made recommendations on implementing an audit of treatment plans to ensure consistency in quality; an urgent review of the psychology provision; ensuring that all consent and authority to treat certificates were valid and for the service to address the outstanding environmental issues.

The response we received from the service included a plan to implement a separate treatment plan review process; the professional lead for psychology was preparing a paper for NHS Lothian senior managers, outlining the psychology provision requirement for the Islay Centre; the multidisciplinary team (MDT) meeting template was to be amended to include consent and authority to treat certificates that were due for review and there was continued engagement with estates department in relation to repairs required.

On the day of this visit, we wanted to follow up on the previous recommendations, meet with individuals, carers and staff as well as looking at the care and treatment being provided in both units.

## **Who we met with**

We met with 10 people and reviewed the care records of seven. No relatives requested to meet/speak with us on the day of or following the visit.

We spoke with the clinical nurse manager (CNM), the senior charge nurse (SCN), the charge nurse (CN), the consultant psychiatrist, speciality doctor, psychology and occupational therapy (OT) staff.

In addition, we made contact with Partners in Advocacy.

## **Commission visitors**

Kathleen Liddell, social work officer

Lesley Paterson, senior manager (practitioners)

## **What people told us and what we found**

We were unable to have detailed conversations with some of the individuals, due to the extent of their communication difficulties as a result of their severe/profound learning disability. During the visit, we observed 10 individuals who were mainly in their individual room areas. We introduced ourselves to a few of the individuals who were accessing the communal areas.

Some of the individuals we saw were able to respond to our interactions by using non-verbal communication, such as smiling, waving and physical gestures. We observed positive and compassionate interactions between ward staff and individuals during our visit and it was evident from our observations and discussions with staff that they had a good knowledge and understanding of the individuals they provided care and treatment to.

We were pleased to see progress in the individuals' circumstances since our previous visit. For some individuals, discharge planning was actively progressing, with clear and structured plans in place. We also saw that new opportunities for meaningful activity in the ward and community had been facilitated for some individuals. These activities promoted the achievement of personal outcomes with the use of positive risk taking and person-centred approaches.

Staff we spoke with told us that they liked working at the Islay Centre and felt supported to undertake their roles. We consistently heard from staff that there had been an increase in the acuity and complexity in the individuals admitted to the ward, whom they described as challenging at times.

We heard and spoke with staff who advised us that they were regularly injured as a result of violent and aggressive behaviours. Despite these challenges, staff continued to demonstrate understanding and empathy towards individuals' and their situations; staff remained committed to supporting the agreed care plans.

The majority of the MDT reported feeling fully involved in discussions and decision-making. We were told that on occasion, there could be differences of professional opinion regarding plans of care however, staff reported that they felt able to raise these issues during MDT meetings.

## **Care, treatment, support, and participation**

We had heard and were able to see the work that NHS Lothian had undertaken in implementing a new person-centred care plan in April 2025. The new care plans had been reviewed on TRAKCare; they had various headings such as mental health, stress and distress, meaningful activity, physical health, activities of daily living, discharge planning and family/carer involvement.

Prior to the person-centred care plans being implemented, Islay Centre used treatment plans which were stored in a paper file. We heard from all staff that we spoke with that although they were positive about the new care plan template, it was a significant change in practice which was taking time for staff to adapt to and implement consistently.

We found the care plans in Islay Centre and Carnethy House to be of mixed quality. We viewed some good examples of care plans that had been completed comprehensively and clearly identified the individuals' care goals, needs and outcomes. These care plans recorded detailed interventions required by the MDT to ensure that the care and treatment was being delivered consistently.

However, other care plans lacked this level of detail, particularly in relation to interventions required. While we saw that information was available across a range of documents and systems, it was not always recorded in the care plan itself, resulting in the absence of a centralised and easily accessible care record.

We discussed with the CNM and SCN that changes in how interventions were being recorded was a concern; detailed interventions were fundamental in ensuring consistency and continuity of care for individuals in Islay Centre and Carnethy House. The CNM and SCN recognised that ongoing work and training was required to ensure all care plans were completed to the same high standard. We also heard that the ward management team planned to implement an audit of the care plans to support quality of information being recorded consistently.

We were unable to see reviews of the new person-centred care plan recorded on TRAKCare. 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. We were encouraged to hear that the senior management team in Islay Centre and Carnethy House had implemented their own review system to monitor individuals progress and effectiveness of care.

We found that 'Getting to Know Me' documentation had been completed for most individuals. For newer admissions, the service was working alongside families/carers to gather personalised information which helped in developing person-centred care plans. We saw positive examples of each individual's participation in the care planning process, which was supported by the use of symbols, signifiers, as well as input from speech and language therapy (SaLT).

We found good examples of proactive discharge planning that evidenced the involvement of the individuals, welfare guardians and where appropriate, relatives. We were pleased to hear that there were regular health and social care partnership (HSCP) meetings to discuss and support discharge planning, as well as attendance

at the dynamic support register group to identify and support individuals who were at risk of unnecessary hospital admissions.

The risk assessments we reviewed were of a high standard. Some individuals had various risks assessments that supported them in the ward and in the community. The level of detail in the risk assessments was comprehensive and included identified risks, a detailed risk management plan and a safety plan. This level of detail supported all staff to provide consistent and informed care across ward and community settings.

We saw that physical health care needs were being addressed, with annual health checks and national screening being completed and followed up appropriately.

All individuals were subject to the care planning approach (CPA). CPA is a framework used to plan and co-ordinate mental health and / or learning disability care and treatment, with a particular focus on planning care through the involvement of a range of different people and by keeping the individual and their recovery at the centre.

We found this paperwork to be of a high standard and reviewed on a six-monthly basis. We raised in the previous report that the information recorded in the CPA did not always align with the care plan. We were pleased to find improved consistency between the information recorded in both documents.

### **Care records**

Information on individuals care and treatment was held electronically on TRAKCare; we found this easy to navigate. The care records were recorded on 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.

The care notes we reviewed were of good quality and evidenced person-centred, individualised information. They detailed activities, what individuals found positive or challenging and how staff supported skill development and independence.

We saw that information recorded in the care records aligned with the treatment plans. We were pleased to see comprehensive recording from all members of the MDT. Information recorded in the care records promoted a holistic and recovery-based approach to the care of individuals in the ward.

From review of the care records, we saw that individuals in the unit had complex needs and, at times, displayed behaviour that was challenging. We saw regular incidents of self-harm and assaults on staff. We were encouraged to note that during these challenging situations, staff demonstrated empathy and continued to focus on supporting individuals' wellbeing, maintaining therapeutic relationships and delivering care in a respectful and compassionate manner.

We were pleased to find that the care records included regular communication with families and relevant professionals. Many of the individuals in the Islay Centre and Carnethy House had involvement with third sector providers. The communication with the providers was clearly documented in care records.

### **Multidisciplinary team (MDT)**

The units had a full MDT on site consisting of consultant psychiatrist, speciality doctor, nursing staff, OT staff, SaLT, and a music therapist.

We met with psychology staff who told us that only one session of psychology provision was being offered in Islay Centre and Carnethy House. We heard that the MDT discussed which individuals should be prioritised for psychological formulation, however it was recognised that all individuals in Islay Centre and Carnethy House would benefit from having a formulation. This would support a shared understanding of the individual's experiences and inform the MDT plan of positive behaviour support (PBS) informed interventions.

We were concerned at the lack of psychology provision in the unit. We heard that since the last visit, funding was agreed for a clinical psychologist post however, initial recruitment was unsuccessful. We were encouraged to hear the post had been readvertised and if this was not successful, the service would consider alternative arrangements to ensure increased psychology provision.

We discussed with the service that the gap in psychology provision had been a recurring concern highlighted by the Commission over several years, and we remain concerned that it continues to adversely impact the delivery of psychologically informed and PBS informed care. We are therefore repeating our previous recommendation and will seek updates from the service.

### **Recommendation 1:**

Managers should urgently review the psychology input in the unit to ensure there is a long-term plan for an appropriate level of input to be in place.

We met with OT staff on the day of the visit. We heard that one of the main roles of the OT was to complete an initial assessment focussing on circumstances leading to admission, to look at what was working well and where there were areas of inpatient support required to facilitate discharge. We heard OT staff worked alongside nursing and third sector providers staff to support aspects of the care plan, such as supporting meaningful activity, positive management of behaviour and consideration of environmental factors.

We were concerned to hear from OT staff that aspects of the ward environment could impact on essential discharge planning. For example, the lack of access to training kitchen facilities limited the ability to assess the individual's skill and risk, which was essential to inform safe and effective discharge planning.

The ward MDT meeting took place on a weekly basis, with individuals being discussed fortnightly. All members of the MDT either attended the meeting or provided a summary of their involvement with the individual. There was clear evidence of social work and mental health officer involvement in MDT discussions and decision-making, particularly in relation to legal status, care and discharge planning. Individuals and relatives/carers were invited to attend the MDT, although CPA meetings were more frequently attended by relatives/carers.

The weekly MDT meeting was recorded using a structured meeting template. We found the quality of the information of the MDT discussions noted in the documentation to be of a high standard; it included decisions and personalised care planning for individuals. All aspects of the individuals' care and treatment was discussed and reviewed, including any restrictions in place and their legal status.

We were pleased to see clear links between MDT discussions, care plans and CPA outcomes. There was evidence that individuals were making progress and moving towards achieving the aims and goals of their admission. It was clear that the MDT was fully engaged in the care of individuals in Islay Centre and Carnethy House and committed to adopting a holistic, strengths-based 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 ECT had been authorised and corresponded to the medication being prescribed.

The electronic prescribing system HEPMA was used on the ward. On cross-checking the records, the responsible medical officer (RMO) had completed T3 certificates for 12 individuals in Islay Centre and Carnethy House. We reviewed the prescribing for all individuals on the ward and found two instances where a prescribed medication was not properly authorised by the T3B certificate in place. We highlighted these errors to the service on the day of the visit and were assured that the identified issues would be resolved by the clinical team.

For individuals who require to receive medication covertly, the Commission has produced [good practice guidance on the use of covert medication](#).<sup>1</sup> Where covert medication was being given, all appropriate documentation was in order.

For those people that were subject to either power of attorney or guardianship under the AWI Act, we found copies of their order and the powers that had been granted; these were recorded on TRAKCare and 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.

## **Rights and restrictions**

The individuals in Islay Centre and Carnethy House had limited understanding of their rights as a result of their severe/profound learning disability. We were pleased that the MDT promoted rights-based care, including supporting referrals to advocacy services.

While the individuals we reviewed were unable to arrange their own legal representation, we were pleased to note that a curator ad litem had been granted to safeguard the interests of the individual in proceedings before the Mental Health Tribunal for Scotland.

We have highlighted in previous reports the high levels of continuous interventions (CI) for many of the individuals in Islay Centre and Carnethy House. We heard that NHS Lothian CI standing operating procedure (SOP) was not fully compatible with the complex needs of the individuals, and the learning disability service was developing their own SOP to ensure consistency of practice.

We were pleased to note that until the new SOP is implemented, CI was reviewed in the MDT meetings and during the CPA process to assess its effectiveness, ensure the interventions remained responsive, personalised and continued to be required.

Two individuals continued to be observed with the use of CCTV cameras in their rooms. We highlighted to the service that the disproportionate use of CCTV may constitute an intrusion into the individual's privacy and dignity which is protected by Article 8 of the European Convention on Human Rights. The presence of a camera may be considered an infringement of privacy and must therefore be proportionate,

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<sup>1</sup> *Covert medication good practice guide*: <https://www.mwcscot.org.uk/node/492>

lawful and have a legitimate aim. We reviewed the records of both individuals and observed staff using CCTV. We were satisfied that care plans clearly documented the rationale for using CCTV, reflected the principles of the Mental Health and AWI Act and were reviewed regularly in the MDT and CPA meetings.

Islay Centre had a seclusion room. We were pleased to be told that the seclusion room had not been used since our previous visit. We heard that seclusion was still occasionally used to manage behaviours that arose through stress and distress, however the use of seclusion had significantly reduced, with more therapeutic interventions being used. We saw that for one individual, bedroom seclusion was used and a corresponding seclusion care plan which detailed a clear rationale and required interventions had been completed.

We observed that some of the individuals spent prolonged periods of time in their 'pods' behind a locked door. We discussed with the service that the Commission would regard this as seclusion and would expect documentation outlining the rationale, legal authority, monitoring, support, and review to ensure safe, individualised and therapeutic care. We raised this with the service, who told us the NHS Lothian seclusion policy was not fully compatible with the needs of the individuals Islay Centre and Carnethy House and that they were developing their own seclusion policy. We will look forward to reviewing its implementation during future visits.

The Commission has produced [good practice guidance on seclusion](#).

We were pleased to hear that the level of restraint in Islay Centre and Carnethy House had continued to reduce. The service had purchased a safety pod to use when restraint was required. We heard that ongoing training was being provided to ensure holds during restraint promoted a more dignified, safe and compassionate approach for individuals who required to be restrained.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements.

The Commission's [good practice guidance on advance statements](#) is clear that the person making an advance statement has to have the 'capacity of properly intending' the wishes specified in it. We did not find any advance statements and it was evident from meeting individuals and reading their care records that they did not have the level of capacity required to make a valid advance statement. However, we were pleased to see that the CPA documentation discussed advance statements and recorded whether the individual was able to participate in the making of this.

We discussed with the CNM and SCN that it remained important that any wishes or views the individuals had were considered when decisions about care and treatment were being made.

Following the visit, the Commission contacted the advocacy services who attended the Islay Centre and Carnethy House. Advocacy services reported positive engagement with staff, describing them as communicative, helpful and generous with their time. Advocates highlighted staff support in helping them understand individuals' needs and behaviours, facilitating joint activities such as walks, and linking them with relevant professionals. Advocacy described ward staff as receptive and responsive, including when there were unannounced visits, supporting effective advocacy involvement.

The Commission has developed [Rights in Mind](#).<sup>2</sup> 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 that were available for individuals both in and out with the ward. Activity in the Islay Centre and Carnethy House was provided by the activity co-ordinator, nursing staff, OT staff and the music therapist. Activities available in the Islay Centre and Carnethy House included music therapy, therapy, outings to the local community parks and cafes, visits to the HIVE day service, arts and crafts and sensory based activities.

Each individual had an activity care plan and timetable that recorded a programme of activities related to the individual's interests, goals and outcomes. The activity care plan was person-centred and focussed on skills building and enhanced those activities that supported the admission outcomes and discharge planning.

We saw from the reviews of care plans and care records that many individuals spent time engaging in community activities, supported by third sector agencies, who had been commissioned by social work to support and facilitate discharge planning. We were encouraged to see that many individuals had made progress towards achieving their activity outcomes, including engaging in horse riding, cycling and swimming. These interventions required positive risk-taking strategies which were clearly planned, proportionate and supported individuals to safely engage in meaningful activities while promoting independence and progression towards discharge.

Activities were recorded in care records. The information provided details on how the individual had participated in the activity, what was positive for the individual and areas which they found challenging and required support with.

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<sup>2</sup> *Rights in Mind*: <https://www.mwscot.org.uk/law-and-rights/rights-mind>

Islay Centre and Carnethy House had support from the Cyrennian's volunteer group to help develop their garden spaces. The Cyrennians attended the unit regularly and offered individual gardening sessions to those who were able to engage.

### **The physical environment**

The Islay Centre consisted of three units, Harris, Rhum and Barra. In addition to the Islay Centre, Carnethy House provided care for another individual.

Each unit in the Islay Centre was accessed separately. Harris could accommodate three individuals, while Rhum and Barra units accommodate four individuals per unit. Each unit had individual 'pods' which included a bed space and en-suite facilities. The pods varied in size with some having room for a small living area with a TV and sofa. Each pod had access to an outdoor garden area. There was also a communal garden that had flower beds and a water sensory area for individuals to use.

We were able to view some of the pods on the day of the visit and saw a variety of environments, some personalised and therapeutic while others were more clinical. We heard that the individual's environment was informed by MDT assessment.

When undertaking a review of the units, we noted that there was a high standard of cleanliness.

In the Commission's three previous reports, we have highlighted our concerns in relation to the environment, specifically in relation to décor being refreshed and repairs being completed. We were concerned that no progress had been made and that the condition of the environment had further deteriorated.

On the day of the visit, we observed that Carnethy House required significant repairs, including faults with the heating system and areas of flooring that had collapsed due to damp conditions. As a result, some areas of the unit were unusable and cordoned off. We also noted that in both units, repairs and improvements to the décor remained outstanding and there was a lack of adequate therapeutic space to support assessment and ongoing care planning, which was a core requirement of the service.

The Commission was concerned that the poor condition of the environment was having a negative impact on individuals' wellbeing, dignity, access to safe and therapeutic care and was placing additional pressure on staff in delivering care safely and effectively.

These issues have been raised to the estates department repeatedly by the service and staff told us they had continually escalated concerns, which we heard had been formally recorded on the service risk register. Despite this, there was a lack of timely and meaningful improvement. Urgent action is now required and the Commission considers that due to the lack of progress to ensure the environment is made safe,

fit for purpose, and able to support the delivery of therapeutic care and will escalate accordingly, this should be escalate to the executive team at NHS Lothian and with the Commission.

**Recommendation 2:**

Managers should escalate the Commission's concerns to an executive level in NHS Lothian, who must take immediate action to ensure Carnethy House and Islay Centre provide safe, fit-for-purpose environments, with urgent remediation of environmental issues, sufficient therapeutic space and clear governance to address long-standing, escalated risks.

**Any other comments**

We were encouraged to hear that Islay Centre and Carnethy House were reviewing care and practice and working towards achieving learning disability accreditation and using this framework to support high quality and consistent practice.

We were pleased to observe 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 demonstrate 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 recommendations regarding the environment in Islay Centre, Carnethy House, and the wider learning disability services at the Royal Edinburgh Hospital over several years. It is concerning that limited progress has been made in addressing these issues, as the condition of the environment does not adequately support assessment and ongoing care planning, which is a core requirement of the service.

## **Summary of recommendations**

### **Recommendation 1:**

Managers should urgently review the psychology input in the unit to ensure there is a long-term plan for an appropriate level of input to be in place.

### **Recommendation 2:**

Managers should escalate the Commission's concerns to an executive level in NHS Lothian, who must take immediate action to ensure Carnethy House and Islay Centre provide safe, fit-for-purpose environments, with urgent remediation of environmental issues, sufficient therapeutic space and clear governance to address long-standing, escalated risks

## **Service response to recommendations**

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza  
Executive director (nursing)

## **About the Mental Welfare Commission and our local visits**

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

### **When we visit:**

- We find out whether an individual's care, treatment, and support are in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia, and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice, and guidance to people we meet with.

Where we visit a group of people in a hospital, care home, or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports, and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line, and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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