Mental Welfare Commission for Scotland

Report on announced visit to:
Ferryfield Community Hospital, Ward 1, 100 Pilton Drive
Edinburgh, EH5 2HF

Date of visit: 14 July 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

Newly renamed Ferryfield Community Hospital, which was previously known as Ferryfield House, is located in the northwest of Edinburgh.

The community hospital had two hospital based complex clinical care (HBCCC) wards. Both wards accept individuals, who have been identified through assessment, as requiring specialist care and treatment. For individuals admitted to Ward 1, they have typically had input from adult mental health services both in the community and as inpatients in the Royal Edinburgh Hospital in Morningside.

Ward 1 is a 25-bedded, mix-sexed ward. On the day of the visit, there were 25 people on the ward with no vacant beds.

We last visited this service in November 2023 on an announced visit and made eight recommendations. We were aware at the time of the last visit to Ward 1, which was based Ellen's Glen House, that the service was experiencing significant challenges in relation to staffing including senior nursing staff, retention and recruitment. Without consistent ward-based nursing leadership, the ward remained in a prolonged state of instability, adversely affecting individuals, their families, and the nursing staff team.

Just a few days prior to our last visit, a senior charge nurse (SCN) from another HBCCC service was brought in to support the team and they, along with their deputy charge nurses had remained in their posts since our last visit in 2023. The ward had since moved from Ellen's Glen House in South Edinburgh to its current location. The move and subsequent transfer of individuals in May 2025 had gone relatively well with individuals and their relatives receiving updates throughout the process. While initially there were some apprehensions raised about the change of location for the ward, people were content with their new environment and staff have embraced the opportunity to continue with the service improvements to ensure person-centred care is delivered.

On the day of this visit, we wanted to follow up on the previous recommendations and had the opportunity to meet with the senior nursing leadership team prior to the visit. We received an update on the progress made in response to our previous recommendations. Both the leadership team and ward-based staff had used the findings from our last visit as an opportunity to implement local service improvement plans. The plans addressed all aspects of care while also focusing on enhancing the skills, knowledge, and professional development of ward-based staff. The aims were to strengthen the delivery of person-centred care and ensure that it remained central to nursing practice and decision-making.

Who we met with

We met with nine people and reviewed the care records of five. We also had the opportunity to hear from three sets of relatives who were positive about their relative's care and treatment.

We spoke with the clinical nurse manager, the SCN, the charge nurse and other members of nursing staff.

Commission visitors

Anne Buchanan, nursing officer

Kathleen Liddell, social work officer

Denise McLellan, nursing officer

What people told us and what we found

We were keen to meet with people to ask them about their experiences of receiving care and treatment in Ward 1. We were aware during our last visit, individuals and their relatives had felt care and treatment fell short of what they had expected and this had caused increasing concerns, especially for relatives.

We met with individuals and received written feedback from their relatives.

Individuals told us they had felt care and treatment had significantly improved, the environment was welcoming and nursing staff were kind and approachable. While it was recognised by both the ward-based team and individuals that having additional nursing staff would be welcomed, their specialist input was appreciated.

This was also recognised by relatives who kindly provided their views and appreciated having a team that were knowledgeable and thoughtful. When we met with individuals, we were told they had good relationships with the team, that they felt safe and were regularly invited to participate in their assessments and care planning.

We were told the activity co-ordinators had a positive impact upon individuals and the available activities were very popular. Furthermore, having a music therapist who provided a psycho-therapeutic model of treatment was hugely appreciated by both staff and individuals. We could see during our care record reviews the role of music therapy had become embedded in the ward's treatment model and was highly valued.

While the feedback received during our visit to Ward 1 was largely positive, concerns were raised regarding the ward's nursing establishment. Individuals we spoke with were highly complimentary of the nursing staff and recognised their commitment and professionalism, however they also acknowledged the significant competing demands placed upon the team and felt that an increase in staffing levels would be beneficial.

Similarly, discussions with the nursing leadership team reflected this view. They advised that 15 newly qualified nurses had recently been recruited to support both services based at Ferryfield Community Hospital. The ward-based team welcomed this development but also recognised that the introduction of a large cohort of newly qualified nurses presented its own challenges. They highlighted the importance of ensuring new staff receive appropriate supervision and support throughout their post-registration consolidation period.

Care, treatment, support, and participation

When we met with the senior nursing leadership team prior to our visit, we discussed the last local visit report and the high number of recommendations; the leadership team had used our last report to support several innovative developments to deliver person-centred care, support relatives and ensure the ward-based nursing team were skilled and knowledgeable to provide care that met the needs of individuals admitted to Ward 1.

We heard the newly appointed senior leadership team were keen to develop systems that could reliably audit record keeping, assessments and care planning. Those were areas that had previously been highlighted as requiring urgent attention.

We were keen to review care records to establish whether the ward had made improvements and whether care could be considered person-centred. All care records were stored electronically on TRAKCare, the electronic record management system used by NHS Lothian.

We reviewed the care records of five individuals and were pleased to find evidence of improvements in record keeping. As part of our review, we considered risk assessments, nursing assessments that had been completed to inform care planning, daily entries documenting day-to-day care, and care plans to determine whether the necessary improvements that had been previously identified had then been implemented.

The nursing assessments we reviewed were comprehensive and demonstrated a person-centred approach. We noted that the '*What Matters to Me'* document had been completed for everyone, and the information captured from this was incorporated into each assessment and care plan. Throughout the assessments, there was clear evidence that individuals' views had been actively sought and that relatives, where appropriate, had been invited to contribute to the assessment and care planning process.

We were also pleased to find that care plans were person-centred, with goals clearly identified by the individual and a shared understanding of how staff would support them to achieve these outcomes. We recognised that some individuals required input from a range of professionals, particularly those with complex physical health needs. It was encouraging to find assessments and associated care plans that were detailed, multidisciplinary in nature, and identified appropriate strategies to support both physical health and mental wellbeing.

We also found evidence that the ward-based team had embedded a strengths-based approach to assessment and care planning. The care records demonstrated an appreciation that, for some individuals, adverse childhood or life experiences could make it difficult to establish trusting relationships with professionals. We saw

evidence that the team had incorporated trauma-informed principles into their practice, recognising the importance of safety, trust, and therapeutic relationships in supporting individuals who had experienced trauma.

We would have expected a detailed overview of individual's day-to-day experiences on the ward, whether interactions had been welcomed, any concerns raised by individuals and whether a scheduled activity had gone well. We saw detailed entries from allied health professionals (AHPs) and from the arts/music therapist, but we were unable to find detailed day-to-day entries in individuals' records with nursing staff; we found that these entries used only perfunctory language to describe an individual's demeanour. We recognised that many individuals admitted to Ward 1 required a high level of support which was reflected in their assessments and care plans therefore, we were disappointed to see terms such as "not offering any complaints" "appears settled" "keeping a low profile" as a way of describing individuals' daily presentations.

Recommendation 1:
Managers should ensure all information recorded in the individual's daily continuation is personalised, meaningful and appropriately describes their clinical presentation and how their day was spent.

While we found individuals had detailed care plans that were person-centred, the care plans were not regularly reviewed or updated where necessary. Care plan reviews are essential as they provide a framework for individuals to identify where they have made progress or need additional interventions to support recovery.

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.

Recommendation 2:
Managers should ensure care plan reviews are undertaken regularly and that individuals are invited to participate in those reviews.

Multidisciplinary team (MDT)
We were told the ward did not have a fully substantive MDT, but referrals could be made to AHPs such as occupational therapy, physiotherapy, and speech and language therapy. Where routine referrals had been accepted and individuals were seen by the relevant AHP, it was recognised individuals would benefit from having a full, regular MDT model of care and treatment.

It was also recognised that the absence of psychology was a considerable loss for individuals, particularly for people who presented with behaviours associated with

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

stress and distress. This was notable, particularly for individuals who had experience of childhood/ lifelong trauma, nevertheless, we were told the ward-based team had opportunities for professional development that included training in relation to trauma informed care.

The ward benefitted from having regular group and one-to-one sessions with a music psychotherapist. We could see from the review of care records that their input supported the principles of arts psychotherapy and was highly valued by everyone.

We were informed that the multidisciplinary team (MDT) met weekly to discuss individuals' care and treatment. These meetings were held on the ward and attended by the recently appointed social worker, nursing staff and medical staff. Medical input was provided by a visiting GP, clinical fellow and consultant psychiatrist.

The ward-based team advised that all individuals had access to a senior medical review with their consultant psychiatrist. Reviews were undertaken either during the weekly MDT meeting or separately at a time agreed between the individual, the ward team and the consultant psychiatrist.

While we were informed that individuals had opportunities to meet with their consultant psychiatrist, we noted that the detail of these reviews was not always consistently recorded within care records. We raised this with the ward-based team and sought assurance that all individuals receive regular senior medical reviews, and that discussions regarding care and treatment are clearly documented in the clinical record.

We reviewed documentation from the weekly MDT meeting and found that the detail of meeting was limited. There was little evidence of wider multidisciplinary discussion, co-ordinated care planning or consideration of discharge planning. We would expect MDT meeting documentation to provide a comprehensive record of multidisciplinary discussion, agreed actions, review of progress and future plans to support coordinated care, treatment and discharge planning.

Recommendation 3:
Managers should carry out an audit of MDT weekly meeting structure and template to ensure all individuals admitted to Ward 1 are provided with documented evidence of how the MDT gather information to support individuals throughout their admission.

Use of mental health and incapacity legislation

On the day of our visit, 19 individuals in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All documentation relating to the Mental Health Act was stored electronically and easily located on TRAKCare.

The individuals we met with during our visit had a mixed understanding of their detained status and their rights under the Mental Health Act. From the records we reviewed, there was evidence of legal representation and advocacy involvement to support individuals in understanding their legal status and how to exercise their rights.

Part 16 (sections 235-248) of the Mental Health Act sets out conditions under which treatment may be given to detained individuals who are either capable or incapable of consenting to specific treatments. This includes the requirement for a second opinion by an independent designated medical practitioner (DMP) for certain safeguarded treatments and the authorisation of medication prescribed beyond two months, when the individual does not consent to the treatment or is incapable of doing so. Treatment must be authorised by an appropriate T3 certificate, or a T2 certificate if the individual is consenting.

We reviewed the prescribing of medications and treatments for all individuals, as well as the authorising of treatment for those subject to the Mental Health Act. Medication was recorded on the hospital electronic prescribing and medication administration system (HEPMA). T2 and T3 certificates authorising treatment were stored separately on TRAKCare, while some certificates were stored as paper copies.

We have previously advised inpatient services across Lothian that navigating both electronic systems simultaneously can be a practical challenge for staff. We would suggest a paper copy of all T2 and T3 certificates be kept in the ward dispensary so that nursing and medical staff have easy access and the opportunity to review all T2 and T3 certificates. Unfortunately, we could not locate current certificates for all individuals who required them. Once again, we proposed this situation was potentially problematic as it could reduce the ease of checking for the correct legal authority for prescribed treatments.

During our review we were concerned to note that several individuals were receiving treatment which was not authorised either by a T2 or T3, meaning that the necessary legal authority was not in place. We brought this to the attention of the ward manager and the senior leadership team. We were informed access to pharmacy services was not always consistent or available. We raised this as a governance issue to the senior leadership team due to the multiple issues we found with the prescription of psychotropic medication and the apparent lack of review/audit of current prescriptions and associated legal paperwork.

Recommendation 4:
Managers, responsible medical officers and nursing staff must ensure that all consent and authority to treat certificates are valid, and that all psychotropic

medication is legally authorised and a robust audit process should be put in place to monitor compliance with this.

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 accompanying paperwork in the care records.

For those people that were subject to the Adults with Incapacity (Scotland) Act, 2000 (AWI Act) their legal paperwork was stored electronically on TRAKCare. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate 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 found section 47 certificates had been completed correctly with evidence of discussion with appointed legal proxy decision makers. All certificates had accompanying treatment plans.

We noted a white board in the duty room with information relating to individuals' legal status. While this is a good way to identify an individual's Mental Health Act or AWI Act information, we became aware the information was considerably out of date for several individuals. This could have meant the clinical team were not aware of important information in relation to individuals care and treatment and legal status.

For individuals who had covert medication in place, all appropriate documentation was in order, with regular reviews to ensure the pathway where covert medication was considered remained appropriate. The Commission has produced good practice guidance on the use of covert medication.[2]

Rights and restrictions

The ward operated a locked door policy commensurate with the level of risk being managed in this setting. There were several individuals who were provided with opportunities to visit their local community and had individual pass plans in place. For others who required staff support, there were care plans in place to support visits into the community that ensured they had access to shops and available activities.

We were told Advocard independent advocacy service offered support and engagement with individuals admitted to the ward, with additional support provided by staff for carers and signposting to designated support agencies.

We enquired how staff provided support in relation to individuals understanding their rights and any restrictions placed upon them. This was particularly relevant to people who were admitted to the ward and continued to receive their care and treatment

[2] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492

informally. Rights-based care has been a part of mental health care and treatment for many years. It has been recognised that individuals who by virtue of their mental ill-health and, who require an admission should expect their rights are at the forefront of any decisions and discussions. For some people this may mean they are subject to detention under the Mental Health Act and will have legal safeguards in place. For individuals not subject to a legal framework and would be viewed as receiving their care voluntarily, they too should be afforded an understanding of their rights. On the day of the visit, we met with individuals who did not require a legal framework to remain in hospital and were aware of their rights and contact details for advocacy services if required.

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

During our last visit to the ward when it was based in Ellen's Glen House, we were told activities were not routinely available and limited in their scope.

We were pleased to have found on our visit to Ward 1 that there were activities available throughout the day, spanning seven days a week. With the benefit of having two activity co-ordinators, individuals could either participate in group activities or one-to-one activities. There was a recognition for some people, meeting in groups was difficult and having opportunities to spend one-to-one time with the activity team was preferable. We were also pleased to see volunteers were welcomed into the ward to spend time with individuals.

Having psychotherapy through art and music had been the mainstay for people admitted to Ward 1 and an important part of the week for the individuals who participated.

While referrals to occupational therapy were routinely accepted, the nursing team did take on additional tasks as part of supporting individuals' recovery and rehabilitation. Budgeting, shopping and cooking sessions in the ward's kitchen were part of the nursing staff's assessment of an individual's strengths and of the areas where they needed additional care planning, to ensure discharge from hospital to independent living could be achieved.

The physical environment

We found the ward to be bright, welcoming and spotlessly clean, which individuals also commented on. The ward had three separate corridors with each

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

accommodating nine ensuite bedrooms, however two of the bedrooms were not currently being used as such.

On the day of the visit, two corridors accommodated females with the third corridor accommodating males. Each corridor had its own separate sitting room, which were all pleasantly furnished and comfortable. The dining room could accommodate everyone for mealtimes, however the staff team recognised that for some people, sharing the same space at mealtimes could be overwhelming; having a quiet space like the conservatory, sitting rooms or their own bedroom was encouraged so individuals could enjoy mealtimes and feel relaxed.

Attractive artwork lined the walls, with colourful and accessible information boards to keep individuals updated in relation to daily activities and which staff were on duty each day. To support individuals with communication, the team had included a 'you said – we did' board. The nursing team recognised the importance of gathering individuals' views and this has been successful by ensuring people felt listened to and their ideas accommodated.

We had the opportunity to visit the garden which was accessible for everyone, planted with many shrubs and flowers. We spoke with individuals who were enthusiastic about the outdoor space and who were happy to spend time enjoying it in the good weather.

We were told by staff that while they were happy with their new environment having moved from Ellen's Glen House, it was quickly apparent there were risks in relation to individual's bedroom doors. Individuals admitted to Ward 1 often presented with physical and mental health comorbidities. For some individuals they may require emergency treatment however, bedroom doors rather than opening out into the main corridors, opened into the bedrooms therefore arriving with emergency equipment could be hindered should the team attempt to treat an individual in crisis.

This issue had been raised through the risk assessment process, including the risk register and escalated to the senior managers. The team had not been provided with reassurances that the potential risk issue will be resolved. We would expect any environmental issues that had the potential to cause harm would be remedied, however the building itself is part of a private finance initiative (PFI) therefore resolving environmental issues had been an ongoing challenge.

Recommendation 5:
Senior managers in Edinburgh Health and Social Care Partnership should escalate the completed risk assessment that includes entry access to individual's bedrooms as a matter of urgency to mitigate the risk of potential harm to individuals who require treatment in an emergency.

Any other comments

Ward 1 admitted individuals who by virtue of their diagnosis and significant mental ill-health required specialist hospital-based care. We heard from individuals how they valued the compassionate person-centred care they had received. While it was clear there were occasions where 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 next visit to Ward 1 to hear how future plans have progressed.

Summary of recommendations

Recommendation 1:
Managers should ensure all information recorded in the individual's daily continuation is personalised, meaningful and appropriately describes their clinical presentation and how their day was spent.

Recommendation 2:
Managers should ensure care plan reviews are undertaken regularly and that individuals are invited to participate in those reviews.

Recommendation 3:
Managers should carry out an audit of MDT weekly meeting structure and template to ensure all individuals admitted to Ward 1 are provided with documented evidence of how the MDT gather information to support individuals throughout their admission.

Recommendation 4:
Managers, responsible medical officers and nursing staff must ensure that all consent and authority to treat certificates are valid, and that all psychotropic medication is legally authorised and a robust audit process should be put in place to monitor compliance with this.

Recommendation 5:
Senior managers in Edinburgh Health and Social Care Partnership should escalate the completed risk assessment that includes entry access to individual's bedrooms as a matter of urgency to mitigate the risk of potential harm to individuals who require treatment in an emergency.

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.

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