Mental Welfare Commission for Scotland

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

Date of visit: 22 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 in the northwest locality of Edinburgh. The community hospital had two hospital based complex clinical care (HBCCC) wards. Both wards accepted individuals who have been identified through assessment as requiring specialist care and treatment.

For individuals admitted to Ward 2, they have typically had an initial assessment in the Royal Edinburgh Hospital older adult wards or admitted from care homes.

Individuals are likely to have been diagnosed with a dementia and due to progression of their illness, enhanced nursing care has been deemed as necessary.

Ward 2 is a 21-bedded female ward. On the day of the visit, there were 19 people on the ward.

We last visited the ward in August 2023, and at that time, we were made aware of the intention to re-design older adult mental health services in Edinburgh. We were informed there would be a reduction in the number of HBCCC wards from four to three, and a gradual move of the three wards from mixed sex to single sex. The re-design had been completed with the wards in Ferryfield Community Hospital and Findlay Community Hospital accepting individuals who required specialist care and treatment due to the complexities of their presentation.

We made three recommendations after our last visit, two of those recommendations were in relation to senior nursing staff undertaking regular quality and governance audits to ensure care and treatment was person-centred. The third recommendation was in relation to the legal authority for treatment given to individuals. We became aware during the last visit that there were individuals who were given treatment that had not been authorised either under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Adults with Incapacity (Scotland) Act, 2000 (AWI Act).

On the day of this visit, we wanted to follow-up on previous recommendations and hear how the re-design of older adult mental health services had progressed. We were also keen to meet with individuals and their relatives, however we were aware for some individuals, due to the progression of their illness, this may not be possible.

Who we met with

We met with six people and reviewed four sets of care records. We also met with five relatives.

We spoke with the clinical nurse manager, senior charge nurse and nursing staff and had the opportunity to meet with and hear their views of working with individuals and their families in Ward 2.

Commission visitors

Anne Buchanan, nursing officer

Tracey Ferguson, social work officer

What people told us and what we found

We were able to meet with individuals and their relatives throughout the day of the visit.

Due to the progression of their illnesses, most individuals could not describe, in any detail, their experiences of Ward 2. Nevertheless, we had the opportunity to sit with individuals or observe their interactions with staff throughout the day.

We could see individuals were largely content, staff were caring and where specific caring duties were required, nursing staff were patient and professional. We met with relatives; they were enthusiastic about the care and treatment their family member was receiving. We were told communication was excellent and information provided by senior medical staff was regular and detailed. We were told the Ward 2 team were "brilliant", staff not only provided support to individuals, but this was extended to families, which was appreciated. We were also told having a senior charge nurse who was available when families needed reassurance was "amazing". The nursing team was praised for their compassion and continuing professionalism.

We also had the opportunity to meet with nursing staff who told us they felt supported by the senior leadership team. Being valued as part of the ward-based team meant they had opportunities for additional training, reflective practice and importantly, had time to care for individuals while supporting their families.

Care, treatment, support, and participation

During our last visit to the ward, we made two recommendations in relation to record keeping, where we specifically drew attention to person-centred care planning and day-to-day recording of nursing care and treatment for every individual in Ward 2. We were keen to see whether progress had been made in both areas.

We were aware individuals admitted to the ward may not have the ability to participate in their assessments and accompanying care plans however, we looked for evidence where the clinical team had made efforts to ensure all care was delivered in response to an individual's assessed needs. To ensure participation and supported decision making, nurses should be able to evidence how they have made efforts to do this and that actions which are part of the care plan are clear and attainable.

We saw care plans that would be considered person-centred and where the individual and their relatives had participated in their creation. We saw how the 'getting to know me' document completed by relatives had directly influenced care that aligned with individuals' past and present wishes. While we saw some care plans that were bespoke, this was not consistent through all care records we reviewed.

We were aware there were several individuals who required an enhanced level of support due to their presentation, as for some individuals with a dementia diagnosis their understanding of surroundings could be difficult to comprehend and that was often the case for recognising people too. Communication could be compromised, therefore individualised care plans, specifically to help and support those individuals, are essential. We saw some care plans that provided interventions and strategies to aid staff to provide safe individualised care however, this was not consistent.

We also were unable to consistently find evidence of where staff had followed specific guidance in individuals' care plans. We would have expected to see a detailed daily narrative of how interventions had helped individuals, particularly during periods of heightened anxiety; that level of documented detail held in an individual's care records allows the reader to appreciate how staff provide support, what helps and where adjustments to care may be required. We brought this to the attention of the senior leadership team on the day of the visit as we were aware there were inconsistencies throughout individuals' care records.

Recommendation 1:
As previously recommended, managers must undertake regular audits of care plans to ensure they are person-centred, reviewed regularly and day-to-day record keeping reflects guidance and support provided by the clinical team.

Care records
We reviewed the care records of four individuals, all care records were stored electronically on TRAKCare, the electronic record management system used by NHS Lothian.

The nursing assessments we reviewed were comprehensive and demonstrated a person-centred approach. We noted that '*What Matters to Me'* and *'Getting to Know me'* documents had been completed for everyone and were incorporated into each assessment and for several individuals, these had influenced their care and treatment.

We were told that pre-admission assessments were undertaken by nursing staff who attended the Royal Edinburgh Hospital to meet with individuals and their relatives, while also reviewing care records. This informed an understanding of an individual's needs prior to admission to Ward 2. There was a clear focus upon an individual's physical health and well-being. There was a recognition that for people who had a dementia diagnosis, their physical well-being was equally as important as their mental and cognitive welfare. We could see evidence of continued assessment and that referrals were made to allied health professionals, when required.

We were told nursing staff were encouraged to attend monthly training sessions on a range of subjects. Those sessions included working with and supporting older adults

with comorbidities associated with a dementia diagnosis, end of life care and supporting families; these sessions would be beneficial in extending the role of the ward-based nurse to promote professional judgement and supporting individual's physical health. Additionally, all staff were provided with guidance and training around an understanding of psychological approaches to care and treatment for older adults with a dementia diagnosis.

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)
We were told the ward did not have a fully substantive MDT, and that referrals could be made to allied health professionals (AHPs), for example, occupational therapy, physiotherapy, dietician and speech and language therapy.

While routine referrals were accepted and individuals were seen by the relevant AHP, it was recognised individuals would benefit from having an 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 stress and distress; nevertheless, the ward-based nursing team had received continuing professional development that provided them with enhanced skills for working with people who presented with heightened distress and anxiety.

What was equally beneficial was the regular, consistent sessions delivered by a music therapist that were available for all individuals admitted to the ward. We could see during our review of the care records that individuals appreciated the relationship with the music therapist.

We were told the nursing establishment was due to increase with five newly qualified practitioners who are due to start in the service over the autumn. They would be supported over their consolidation period to ensure they felt confident and skilled to support older adults who present with complex needs.

The ward also benefited from having input from a clinical fellow (medical) and a consultant psychiatrist who we were informed by relatives was approachable, keen to listen and to discuss care and treatment with families. The ward also benefitted from having input from an advanced nurse practitioner; their role in the ward supported both the nursing and medical team and they had specific expertise in how to enhance physical health care.

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

There were regular MDT meetings in which relatives were invited to participate, where nursing staff provided a detailed review of each individual to be discussed. We could clearly identify where each discipline had provided input, outcomes and actions required from each meeting.

We were informed there were six individuals who were considered delayed in terms of their discharge from hospital-based care. This was largely due to the complexity of their presentation and the challenge in locating nursing or care homes that could accommodate their assessed needs. For the six individuals, there were regular updates and communication from the local authority to support the clinical team and individual's relatives.

Use of mental health and incapacity legislation

On the day of our visit, 13 individuals in the ward were detained under the Mental Health Act. All documentation relating to the Mental Health Act was stored electronically on TRAKCare and in each individual's folder, which held all legal paperwork including the AWI Act documentation, such as section 47s, power of attorney certificates and copies of welfare guardianship orders.

The individuals we met with during our visit had limited 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. There were no individuals who could provide their consent for treatment therefore, all individuals who required a T3 certificate had their treatment legally authorised by this.

For those people who were subject to the AWI Act, we found individuals all had separate folders collating key information related to them. This meant that important information was kept together, for example certificates authorising medical treatment, decisions in relation to do not attempt cardiopulmonary resuscitation (DNACPR) and anticipatory care planning.

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 found all section 47 certificates were completed and had accompanying treatment plans. Where required we could see evidence of discussion with legal proxies, for example welfare guardians.

For individuals who had covert medication in place, all appropriate documentation was in order, with review dates in place.

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 HBCCC setting.

We were told Advocard independent advocacy service offered support and engagement with individuals admitted to the ward, with additional support provided for carers by staff 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 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 to hospital should expect their rights to be 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. While many individuals would not have been able to engage in detailed discussions, we were pleased to hear during our discussions with relatives that they felt fully informed of their relative's care and were actively encouraged to participate in reviews.

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.

[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

Activity and occupation

Ward 2 benefitted from having two activity co-ordinators individuals who could either encourage participation in group activities or in one-to-one activities; there was a recognition that for some people, meeting in groups was difficult and having opportunities to spend time with the activity team was preferable. We were also pleased to see volunteers were welcomed into the ward to spend time with individuals.

The ward's activity room was bright, welcoming and offered a range of sensory materials for individuals to enjoy working with. There was a clear focus embedded in the ward's model that encouraged regular activity and occupation for people who, by virtue of their dementia diagnosis, could find their daily routines challenging and by providing activities, their stress and anxiety was greatly reduced.

Furthermore, having psychotherapy through art and music has been the mainstay for people admitted to Ward 2. We were told these were highly valued and an important part of the week for the individuals who participated.

The physical environment

We found the ward to be bright, welcoming and spotlessly clean. Each individual bedroom had en-suite facilities and was personalised with family photos; the 'getting to know me' and 'what matters to me' information boards invited relatives to help in the completion of these. Having detailed information about an individual's work history, hobbies and family life provided staff with opportunities to have conversations with individuals based upon their life history.

The ward had three corridors with bedrooms and separate sitting rooms which were very comfortable, bright and welcoming for individuals and their families. While people could use the spacious dining room to enjoy mealtimes, it was also recognised for some individuals sharing what could be a busy space could feel overwhelming, therefore staff also supported individuals to enjoy their meals either in their own rooms, the sitting room or the bright, comfortable conservatory.

Outside space and gardens were well designed, accessible for individuals and their families, and offered a range of flower beds and seating to add interest. Staff had access to their own garden, which had also been designed to promote reflection and relaxation.

Signage throughout the ward was clear and encouraged individuals to recognise their own bedrooms and communal rooms. Information boards were regularly updated, and included activities available throughout the week and information for visitors and families.

Any other comments

We met with relatives throughout the day of the visit to Ward 2. It was clear that they felt listened to and actively encouraged to participate in designing care and treatment for their family member. Staff were compassionate, professional and communicated well so families felt happier and more content with their relative's experience of care in Ward 2.

Summary of recommendations

Recommendation 1:
As previously recommended, managers must undertake regular audits of care plans to ensure they are person-centred, reviewed regularly and day-to-day record keeping reflects guidance and support provided by the clinical team.

Service response to recommendations

The Commission requires a response to this recommendation 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



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