Mental Welfare Commission for Scotland

Report on unannounced visit to:
Royal Edinburgh Hospital, Cramond Ward, Morningside Road, Edinburgh, EH10 5HF

Date of visit: 15 July 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

Cramond Ward is a 14-bedded, mixed-gender, intensive rehabilitation ward in the Royal Edinburgh Hospital (REH) that provides treatment for adults, usually between the ages of 18 and 65, who have ongoing complex care needs.

Individuals in Cramond Ward are likely to suffer from either a psychotic illness or a mood related illness that is complicated by treatment resistance, substance misuse, physical health issues, and/or difficulty in engaging with health and social care services. On the day of our visit, there were 14 individuals on the ward and no vacant beds.

Referrals to the ward are received from a number of sources, including inpatient acute mental health services, community and forensic mental health services. Those who are referred are likely to have had contact with mental health services for a prolonged period of time.

The objective of Cramond Ward is to provide intensive rehabilitation to those with complex and enduring mental health needs, with the aim of preparing and supporting individuals to be discharged into the community.

We heard and observed that some of the individuals in Cramond Ward had reached their rehabilitation potential; there were eight individuals whose discharge had been delayed due to them requiring services that were either hospital based complex clinical care (HBCCC) or community services. We heard during the last visit that the health and social care partnership (HSCP) were commissioning a service in the community for individuals who require a rehabilitation service, as there was a gap in service provision to meet the complex needs of these individuals. We were concerned to hear that no progress had been made in this planning and the negative impact this had on discharge planning.

We last visited this service in November 2022 as an announced visit and made one recommendation in relation to ensuring treatment was authorised by the conditions set out in Part 16 of the Mental Health Care and Treatment (Scotland) Act, 2003 (the Mental Health Act). The response we received from the service was implementation of a structured ward round document that would record consent and authority to treat certificates alongside a clear plan of treatment.

On the day of this unannounced visit, we wanted to follow up on the previous recommendation, meet with individuals, relatives/carers and staff.

Who we met with

We met with and reviewed the care of six people. We also met spoke with four relatives.

We spoke with the clinical nurse manager (CNM), the senior charge nurse (SCN), other nursing staff, student nurses, the music therapist and the recreational nurse.

Commission visitors

Kathleen Liddell, social work officer

Anne Buchanan, nursing officer

What people told us and what we found

The individuals we met with on the day of the visit were mainly positive about their care, support and treatment in Cramond Ward. Their feedback included comments such as “I feel safe”, “staff are supportive and helpful”, “the care I receive is holistic as all members of the team are involved in my care”, “the support I get is helping my rehabilitation goals”, “my physical health is the best it has been in many years”.

Other feedback was less positive and included comments such as, “I feel too restricted” and “I am not fully involved in decisions regarding my care”. We were concerned by these comments and reviewed the care records of these individuals.

We were able to see from reviewing the care records and in our discussions with staff that any restrictions that were in place were legally authorised, reviewed regularly and discussed with individuals in the weekly multidisciplinary team (MDT) meeting and during one-to-one interventions with nursing staff. We acknowledge that restrictions can be challenging for individuals to accept; however, we were satisfied that the restrictions were proportionate to the level of assessed risk, supported the individual’s safety and represented the least restrictive option necessary to achieve maximum benefit.

All individuals told us they had a key nurse that they met with regularly. We heard that the regular one-to-ones with staff were “very supportive” and beneficial to individuals as this time was used to discuss their views and areas of their care that they were unhappy with or that were working well.

Some individuals were aware of their care plan and told us they had participated in the completion of it. Others said that they were unaware of their care plan, had not had any involvement and would like increased opportunity to have greater involvement in their care plan and decisions regarding their care and treatment.

We heard that some individuals did not feel that their views were listened too, especially at the weekly MDT meetings. We spoke with the SCN on the day of the visit and were told that care planning was regularly discussed with individuals in Cramond Ward at these meetings and during one-to-one interventions with nursing staff. In some cases, we heard that individuals had opted out of being involved in their care plan, as their view was they did not need to be in hospital. We discussed that nursing staff should reflect this view in the care plan and develop strategies to support increased participation in the care planning.

Many of the individuals we met with told us they felt frustrated at the amount of time they had been in hospital. Some individuals did not feel as though they needed to be in hospital and were concerned there was no discharge planning in place for them. These individuals told us that they had access to advocacy services and that they

had provided their views to the MDT during these weekly meetings and at the three-monthly integrated care pathway (ICP) meetings.

All of the individuals we met with provided positive feedback on the activities available. In particular, individuals spoke positively about the occupational therapy (OT) groups, psychological therapies available in the ward, music therapy and contact with the recreational nurse. All individuals fed back that there was a good variety of activities to support their rehabilitation needs as well as promoting their interests/hobbies.

Many of the individuals we met with shared a bedroom with no en-suite facilities. We heard from individuals that they felt their privacy and dignity was compromised and that they would prefer if they had their own room and access to a private bathroom.

Relatives spoken with provided mixed feedback regarding the care, treatment and support their loved one was receiving in Cramond Ward. Relatives commented that they were able to see progress being made in some aspects of their loved one's care however, felt that there was limited progress in other aspects, which caused them concern, specifically in relation to how this negatively impacted on discharge planning. Some relatives had made formal complaints to NHS Lothian regarding these concerns and were not always satisfied with the complaint outcome.

Some of the relatives discussed restrictions that were in place and generally agreed that the structure and routine in Cramond Ward had supported their loved one and promoted their recovery. However, there were occasions that they felt the level of restrictions, mainly in relation to passes off the ward, were not always necessary. Relatives said that they had attempted to raise this with the MDT, however, did not feel their views were listened to and did not feel fully involved in these decisions.

Most relatives provided positive feedback about the range and availability of activity in Cramond Ward. Some relatives commented that their loved ones had learned new skills that would support them when discharged into a community setting.

All relatives reported having positive relationships with the majority of staff in Cramond Ward. However, some relatives expressed concerns regarding the manner in which certain staff members engaged with individuals, particularly when implementing restrictions. It was felt that, on occasion, the approach lacked empathy and could be perceived as punitive.

Relatives spoke highly of the SCN, commenting that they were supportive and approachable. Relatives welcomed the SCNs willingness to make time to meet with families to address any concerns or issues.

We heard that some families had engaged in family therapy supported by the psychologist, which they found beneficial. The relatives we spoke with were aware of the carers group and those who had attended found it helpful and supportive.

All relatives we spoke with raised significant concerns over the ward environment. We heard comments including, “the ward is not fit for purpose”, “it’s appalling there is no ensuite facilities and outdoor space” and “the environment does not support rehabilitation care”. There was a shared view among all relatives that the recovery of their loved ones would be better supported in an environment that offered appropriate and sufficient facilities to meet the complex physical and mental health needs of individuals.

We met with various members of the MDT during the visit. The majority of the staff that we spoke with told us that they enjoyed working in Cramond Ward. There had been a change in the ward management team with the SCN taking up post in March 2025. Staff we spoke with commented that this was a positive change and they felt supported to undertake their role by the SCN. We were pleased to hear that the ward was fully staffed and the use of bank staff was minimal.

We heard that training and skill development was actively promoted and encouraged to support staff to enhance and maintain the specialist skill set, and knowledge required to work in mental health rehabilitation. We were pleased to hear that the addition of psychology to the team provided an opportunity to offer reflective practice to staff. We also heard a recent workshop had been delivered on emotionally unstable personality disorder.

Some staff expressed concerns about the ward environment and the potential negative impact it may have on providing effective care. While we observed that the team had made efforts to create a homely and comfortable environment, the physical environment of Cramond Ward was not well suited to meet the complex needs of the individuals being care for. Staff highlighted particular issues, including a lack of privacy due to shared bedrooms and limited access to appropriate washing and toileting facilities.

We also heard from staff about their frustrations regarding the lack of progress in the planned redevelopment of the Royal Edinburgh Hospital (REH) where rehabilitation services were intended to be reprovisioned. Additionally, staff raised concerns about the limited availability of community-based services to meet the care and support needs of individuals currently in rehabilitation services, which contributed to delays in their discharge.

Care, treatment, support, and participation

We were told and saw that NHS Lothian had implemented a new person-centred care plan on 30 April 2025. The SCN told us that the majority of the information had been

transferred over to the new care plans however, there remained aspects of the care plan that required completion and that this was a work in progress.

The new person-centred care plans that we reviewed on TRAKCare, NHS Lothian's electronic information system, had various headings, including, mental health, stress and distress, activities of daily living, legislation, substance misuse, physical health, risk and activity. The Commission would expect a rehabilitation service care plan to be underpinned by a whole-systems approach, with a clear focus on recovery. We were satisfied that the newly implemented care plans reflected and supported this model of care.

The care plans reviewed were of mixed quality. We saw some good examples of care plans that clearly documented the individuals' goals and aims, along with the interventions required by the MDT to support the individuals achieve the identified goals and aims. These care plans were individualised, goal focussed, person-centred and adopted a strengths-based, holistic approach. However, other care plans lacked this level of detail, with some sections incomplete. We were informed by the SCN that work was ongoing to complete all care plans.

In addition to care plans, all individuals in Cramond Ward had a completed ICP document. We found the ICPs contained comprehensive and detailed information that reflected a holistic approach to care and treatment. The documentation included psychological formulations and demonstrated the involvement of the individual, their family, and all members of the MDT. We were satisfied that key information relating to care, treatment, and support was clearly documented and easily accessible within the ICPs.

We saw that some of the individuals in Cramond Ward had been in hospital for a prolonged period. The Commission's 2020 report on rehabilitation services highlighted the link between long-term mental health problems and an increase in physical health problems. From review of the care records, we found that some of the individuals in Cramond Ward had physical health care needs and we were pleased to find that there was a significant focus on physical health care, with evidence of these specific needs being addressed and followed up by medical staff. We also saw evidence of individuals being supported to attend routine and national health screening appointments which are essential in reducing health inequalities for individuals in hospital.

On review of the care plans, we found evidence of a culture that supported a healthy lifestyle, particularly in relation to diet, exercise and mental well-being. The OTs in Cramond Ward provided opportunities for individuals to engage in regular exercise and support with diet and nutrition. Individuals we spoke with told us that their physical health had improved since admission to Cramond Ward. We were able to see these improvements reflected in the care records. We were pleased to note that

individuals were being offered regular input from spiritual care to promote spiritual well-being.

For the eight individuals whose discharge was delayed, a range of comprehensive assessments had been completed to ensure that no gaps in care or treatment were contributing to the delay. We were pleased to see that the MDT had adopted an assertive and proactive approach to discharge planning.

We also heard that the rehabilitation service met weekly with the discharge co-ordinator to review and discuss all individuals whose discharge was delayed. In addition to this meeting, the rehabilitation service continued to actively explore alternative options across the wider service to better meet the needs of the individuals currently in the rehabilitation inpatient service. One example of this approach was consideration of establishing a dedicated ward for individuals who have been assessed as requiring HBCCC.

Many individuals we spoke with expressed frustration about the lack of information regarding their discharge planning. From our review of the care records, we were able to understand and share this concern, particularly given that decisions about discharge planning had already been made and the reasons for the delays were well known and documented. We were concerned to learn that discharge planning was not being regularly discussed during weekly MDT meetings. This gap in communication may be contributing to the frustrations felt by some individuals awaiting discharge.

The Commission raised this issue with the CNM and SCN, highlighting the importance of ensuring that discharge planning is regularly discussed in the MDT meetings and the need for comprehensive discharge planning information to be clearly recorded and regularly communicated to individuals. The CNM and SCN acknowledged that more regular discussion of discharge planning within MDT meetings was necessary. However, they also highlighted a concern that some individuals may find these discussions distressing, particularly in cases where no progress was being made toward discharge due to external factors, such as a lack of suitable placements or care packages

We found the risk assessments that we reviewed to be of mixed quality. Many recorded extensive historical information from previous hospital admissions, which made it difficult to clearly identify the current assessed risks. While some risk assessments recorded helpful summaries of both historical and current risks, we found that key information regarding risk management was often missing.

We found that many risk assessments had not been reviewed regularly and did not accurately reflect the information recorded in the individuals current care records. When we reviewed the weekly MDT meetings and ICP records, we found that

changes to the assessed risk had been discussed and documented, yet updates were not reflected in the formal risk assessments recorded on TRAKCare, which concerned us. We would expect risk assessments to be kept up to date, to clearly reflect the current risks and to include a comprehensive and current risk management plan that aligns with all clinical records.

Recommendation 1:
Managers must ensure that risk assessments reflect current identified risks, are reviewed regularly and include a comprehensive and current risk management plan.

Care records
The care records were stored on TRAKCare using a pre-populated template with headings aligned to the individuals' care plans**,** helping to ensure consistency and continuity in achieving care, treatment and support outcomes.

From our review of the care records, we saw that some individuals in Cramond Ward required high levels of staff motivation to engage in their care plan. We saw that all members of the MDT were involved in providing regular prompting and support to individuals in the ward to support them to engage in their care plan goals to promote their recovery.

On review of the care records, we found the information recorded was mainly comprehensive and individualised, with information being recorded by all members of the MDT. The information was person-centred, strengths-based, outcome and goal focussed. It was evident from reading the care records how individuals had spent their day, which MDT members had undertaken interventions with them and the outcome of interventions.

We highlighted in our last report that we did not find evidence of regular one-to-one interactions between individuals and nursing staff. We were told that there was a quality improvement project taking place to improve the documentation of one-to-one interventions. We were pleased to find a significant improvement in the recording of one-to-one interactions which were taking place regularly.

The individuals we met with told us that they met with their key nurse and other members of the MDT regularly. The one-to-one interactions reviewed were comprehensive, personalised and strengths-based. We saw positive and regular examples of staff promoting rights-based care by having discussions with individuals regarding views on their care plan, future planning and any issue of concern.

We were pleased to find that the care records included regular communication with families, welfare guardians and relevant professionals, including community teams.

Multidisciplinary team (MDT)

The ward had a broad range of disciplines either based there or accessible to them. In addition to the nursing staff, there was a consultant psychiatrist, junior doctors, psychologist, music therapist, OT and recreational nurse. We heard that the ward clerk, housekeeper and domestic staff were valued members of the MDT. We saw that the MDT had good links with mental health officers (MHOs) and social workers.

We were pleased to see the addition of psychology in the MDT, particularly as we highlighted our concern with the gap in psychological provision in our previous report. We found that individuals were now receiving psychological support both through one-to-one sessions and group-based interventions. We heard and saw that psychology was providing a range of therapeutic interventions, including psychoeducation, distress tolerance, and groups focused on emotional regulation. We were also encouraged to see that in some cases; families had been offered support from the psychologist.

The psychologist attended MDT and ICP meetings and met with individuals who required one-to-one support identified at these meetings. Psychological formulations were completed as part of the ICP process and supported a collaborative approach to the individuals' care, treatment and support by developing a shared understanding of the individual's difficulties and exploring factors that contributed to challenges.

We met with the music therapist and heard and saw that individuals were offered music therapy on a one-to-one basis and in group settings. We were told that the aim of music therapy was to support regulation of emotions, manage distress, enhance communication and interpersonal relationships and support self-esteem and confidence. Individuals and staff spoke very positively about having access to music therapy as it supported their emotional, cognitive and social needs by offering a safe and supportive environment which promoted well-being.

The ward MDT meeting took place weekly in the ward. Individuals and relatives/carers were invited to attend. We heard and saw that individuals regularly attended the MDT meeting. Some individuals told us that they did not always agree with the decisions made. We saw the MDT took steps to discuss these decisions with individuals, providing a clear rationale why the MDT felt the decision made was necessary at that stage in the individuals' care.

We found MDT meetings were recorded to a high standard. A structured ward round template was used and recorded comprehensive information on the MDT discussions and decisions. These included the views of the individuals and their families ensuring care planning was personalised and person centred.

We were pleased to see clear links between MDT discussion, the ICP and care plan outcomes. Everyone in the MDT was fully involved in the care of the individuals in

Cramond Ward and committed to adopting a holistic approach to care and treatment.

We saw that where discharge planning was progressing, the community rehabilitation team (CRT) were involved to support discharge.

Use of mental health and incapacity legislation

On the day of the visit, all 14 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) was electronically stored on TRAKCare and easily located.

Part 16 (section 235 to 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 medications 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 found during our previous visit that not all prescribed medication was legally authorised and made a recommendation that the responsible medical officers must ensure that all consent and authority to treat certificates were valid and record a clear plan of treatment.

We were disappointed to find that, upon reviewing current prescribing practices and authorisation of treatment for individuals subject to the Mental Health Act, there had been no improvement. We remain concerned to have identified a number of prescribed medications that were not legally authorised**.**

This issue was raised directly with the consultant psychiatrist during our visit, and we advised that all individuals affected must be informed and made aware of their rights under the Mental Health Act in relation to consent to treatment.

Recommendation 2:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, that all psychotropic medication is legally authorised and that an audit system is put in place to monitor this.

Medication was recorded on the electronic prescribing system HEPMA (hospital electronic prescribing and medicines administration). T2 and T3 certificates authorising treatment were stored separately on TRAKCare. It is a common finding on our visits that navigating both electronic systems simultaneously can be a practical challenge for staff. This is potentially problematic, as it can reduce the ease

of checking the correct legal authority is in place when prescribing and dispensing treatment for those who are detained.

On our visit to Cramond Ward, we found this to be the case and for this reason, we advised to the SCN that a paper copy of all T2 and T3 certificates should be kept in the ward dispensary, so that nursing and medical staff have easy access to this, and there is an opportunity to review all T2 and T3 certificates. The SCN agreed to action this, and we look forward to seeing this at our next visit.

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 someone had nominated a named person, we found this documentation recorded in TRAKCare.

For the individuals who were subject to the AWI Act, we found copies of the order and powers granted recorded on TRAKCare and that there was regular communication with the guardians.

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 one section 47 certificate and found no issues. The certificate was appropriately completed and compliant with the legal requirements.

Rights and restrictions

Cramond Ward continued to operate a locked door, commensurate with the level of risk identified with those in the ward.

The individuals we met with during our visit had a good understanding of their rights and detained status, where they were subject to detention under the Mental Health Act. All of those we met with were aware of their right to advocacy support and all had active advocacy involvement, provided by the local mental health advocacy service, AdvoCard. All individuals had legal representation and had been supported to exercise their rights by appealing their detention. For individuals who were assessed as not being able to instruct a solicitor, we saw that a curator ad litem had been appointed to safeguard the interests of the individual in the proceedings before the Mental Health Tribunal for Scotland.

We were pleased to see that information on rights was promoted in a variety of ways in Cramond Ward and information was sent to the individual and named persons by the responsible medical officer (RMO) detailing legal status, their rights in relation to this and contact numbers for advocacy to support individuals and named persons to

exercise their rights. We noted that MDT and ICP meetings also reviewed and discussed rights.

The REH has a patient council group that offered collective advocacy and drop-in sessions that some of the patients in Cramond Ward attended.

S281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where an individual is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. Three individuals were specified on the day of the visit. We were able to locate the documentation and reasoned opinion authorising the restrictions. We were satisfied that the restrictions were proportionate to the assessed risk, the least restrictive principle had been applied and the individual was informed of the restrictions during regular review and made aware of their rights.

The Commission has produced good practice guidance on specified persons[1].

When we are reviewing care records, we look for copies of advance statements. The term 'advance statement' refers to written statements made under s275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. On the day of the visit one person had an advance statement in place. Most of the individuals we met with were aware of advance statements and had chosen not to complete one. It was evident during our review of the care records and in discussion with some of the individuals that they were not at a point of their recovery to be able to make decisions regarding their future care and treatment.

The Commission has developed *Rights in Mind.*[2] 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 in Cramond Ward. The activity and occupation in the ward was provided by the recreational nurse, OTs, nursing staff, music psychotherapist and volunteers. The individuals we met with spoke very positively and were complimentary about the activities offered in the ward and at the HIVE day service based in the grounds of the hospital.

[1] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512
[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

There was an activities board located in the ward that provided information on the activities that were on offer. The activities available included music therapy, decider skills, pool competition, branching out group, art group, bingo, pamper sessions, music jam, smoothie group, cooking group, toastie group, arts and crafts and mindfulness groups. We saw that volunteers attended the ward and provided therapet and pamper/hand massage sessions.

We heard that the recreational nurse arranged a 'cake and catch up' on a weekly basis. This was an informal drop-in group for individuals to attend and discuss their views on activities as well as any ward issues.

There was a dedicated activities room in the ward which was bright and welcoming. The walls were decorated with various artwork and positive affirmations, helping to create a therapeutic environment that encouraged individuals to engage in meaningful activity.

We were pleased to see that individuals were able to access activities out with the ward; some of these were provided by third sector organisations. These activities included The Hive, where individuals could engage in activities and socialise with others in the hospital. Some individuals attended the Glasshouses for gardening activities with support provided by the Cyrennians and Artlink. We heard that staff had arranged activities in the garden and occasionally in the community. We were told that staff hoped to arrange some trips to the Edinburgh Fringe Festival.

We also saw and heard that individuals were offered activities to enhance daily living skills and promote rehabilitation outcomes. Individuals were supported to 'deep clean' their room weekly with the support of the housekeeper, domestic staff and their key nurse. Individuals were supported to launder their own clothes. Many individuals engaged in cooking groups and enjoyed cooking their own meals

The physical environment

Cramond Ward was located on the first floor of the original part of the Royal Edinburgh Hospital. There was wheelchair access to the ward.

Cramond Ward was newly refurbished prior to opening in 2020. The ward was a mixed-sex environment, with a mixture of single rooms and shared rooms therefore the physical environment had to be managed differently from other rehabilitation wards in the hospital, to ensure individuals feel safe and comfortable in the ward setting. The bedroom areas in the ward were mainly divided into a male and female area.

Many of the rooms did not have access to en-suite toilet and showering facilities; individuals in their own rooms shared a bathroom. We heard from individuals who shared their bedroom area that they felt they were not afforded the same level of

privacy, dignity and safety that a single room would provide and that they felt this was an infringement of their human rights.

We were able to view a bedroom that was used for someone on their own and a shared bedroom. Both were personalised and clean. The housekeeper supported individuals on a regular basis to tidy and clean their rooms, as well as supporting them with their laundry. The cleanliness of the ward was of a high standard.

There was a communal dining room in the middle of the ward where individuals and staff tended to gather to socialise and engage in activities. In addition, there were separate male and female sitting rooms, both of which had been recently painted which promoted a clean and spacious environment. These rooms had soft seating, artwork and a range of activities including table tennis table and Xbox, creating a comfortable and welcoming environment as well of offering individuals access to a private and relaxed space.

We heard from individuals and relatives/carers that they had significant concerns over the current environment, especially in relation to the limited privacy compared to other wards in the REH and the lack of access to outdoor space and a garden area. While we acknowledge that the location of Cramond Ward provides challenges in providing outdoor access, the insufficient access to outdoor space remains a concern for us, the staff team and relatives/carers. We consider it important for individuals who are experiencing stress and distress, have access to safe outdoor space to support their well-being and recovery.

Although we were pleased by the proactive efforts of the staff team to improve the environment for the individuals in Cramond Ward, it would be preferable that plans for the new build as part of the REH redevelopment project were progressed. This would ensure that individuals are cared for in an environment that better promotes their safety, privacy and dignity.

We were concerned that the individuals' rights to privacy and dignity, which is protected by Article 8 of the European Convention on Human Rights, were being compromised due to the current environmental factors.

Recommendation 3:
Managers should consider ways to achieve parity in relation to the ward environment, garden access, privacy and dignity for all individuals in the Royal Edinburgh Hospital.

Any other comments

Feedback from individuals and relatives regarding their experience of care and treatment in Cramond Ward was mixed. It was evident that some individuals were finding it difficult to accept the boundaries and restrictions in place. Relatives

generally agreed that, in most cases, the structure and restrictions were proportionate and had supported their loved ones' progress in recovery. However, a consistent theme emerged around the experience of restrictive practices, with some staff managing these more effectively than others. While we were satisfied, based on the care records reviewed that the restrictions in place were proportionate to assessed needs and risks, we continue to encourage the MDT to involve individuals and their relatives/carers in ongoing discussions about care and treatment, to ensure that rights-based care is consistently promoted.

We saw and heard evidence of positive leadership provided by the CNM and SCN. It was also encouraging to hear from all staff spoken with that they felt well supported. We were pleased to observe the positive working culture that the SCN had promoted in the ward. It was evident that the ward operated with a clear ethos of supporting staff to deliver high standards of care, underpinned by a holistic, strengths-based, and recovery-focused approach.

Summary of recommendations

Recommendation 1:
Managers must ensure that risk assessments reflect current identified risks, are reviewed regularly and include a comprehensive and current risk management plan.

Recommendation 2:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, that all psychotropic medication is legally authorised and that an audit system is put in place to monitor this.

Recommendation 3:
Managers should consider ways to achieve parity in relation to the ward environment, garden access, privacy and dignity for all individuals in the Royal Edinburgh Hospital.

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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