Mental Welfare Commission for Scotland

Report on unannounced visit to:
The Royal Edinburgh Hospital, IPCU, Blackford Ward, Morningside Place, Edinburgh, EH10 5HF

Date of visit: 29 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

Blackford Ward is the intensive psychiatric care unit (IPCU) for the City of Edinburgh, East Lothian and Mid Lothian. It is a 10-bedded, mixed-sex unit with a separate high dependency unit (HDU).

IPCUs provide intensive treatment and interventions to individuals who present an increased level of risk and require a more individualised, intensive level of observation. This type of unit generally has a higher ratio of staff to individuals and a locked door. It would be expected that staff working in an IPCU have particular skills and experience caring for acutely ill and often distressed individuals.

We last visited this service in October 2024 on an announced visit and made no recommendations.

On the day of this visit, we wanted to meet individuals, family members and staff and review the care and treatment which was being delivered on Blackford Ward.

Who we met with

We met with, and reviewed the care of seven people, three who we met with in person and seven who we reviewed the care notes of. We also met with one relative.

We spoke with the senior charge nurse (SCN), charge nurse (CN), nursing staff and consultant psychiatrist.

In addition, we met with City of Edinburgh mental health officer (MHO) who has contact with the service.

Commission visitors

Kathleen Liddell, social work officer

Susan Hynes, nursing officer

What people told us and what we found

The individuals we met on the day of the visit provided mainly positive feedback about their care and treatment in Blackford Ward. The feedback included comments such as “staff offer me good care and support”, “staff are able to recognise when I need more support which is helpful to me”, “I like my consultant psychiatrist, they listen to me and see me regularly”.

Individuals spoken with commented that the ward environment was mainly calm and that they felt safe. We heard that this was due to staff “being on it” and using skilled nursing interventions to prevent challenging situations escalating.

One individual said that they did not always agree with decisions made about their care and treatment however, told us that they felt listened to by the consultant psychiatrist who took the time to explain the reasons why the multidisciplinary team (MDT) felt the care and treatment was necessary. Individuals told us that this information supported them to gain a better understanding of the decisions made by the MDT.

All individuals told us that they met with their consultant psychiatrist regularly and found these meetings supportive. We heard and saw that individuals did not attend the weekly MDT meeting. The individuals spoken with told us that they were happy with this arrangement, as they preferred meeting with MDT members individually to discuss their care and treatment.

We discussed restrictions with individuals and heard that the restrictions in place in the IPCU environment could cause some frustration. We were pleased to hear that individuals generally experienced restrictive measures being regularly reviewed, proportionate, and responsive to their progress. Individuals reported that restrictions were reduced appropriately as they made progress, and that these decisions were clearly communicated and discussed with them.

Some of the individuals we met with were aware of their care plan and were able to discuss their care and treatment; others were not aware of their care plan. One individual told us that due to their symptoms, they were unable to engage in any care planning at that time however, felt that all members of the MDT made efforts to support their involvement in decision making regarding their care and treatment

Individuals that we spoke with were positive about the wide range of activities available to them, commenting that they enjoyed engaging in the activities on offer. Individuals told us that use of passes was important to them and generally found that staff ensured that individuals’ agreed pass time was prioritised.

We met with one relative. The feedback from the relative was positive. We heard that nursing staff were “excellent, friendly and approachable”. We heard there was good

communication, with staff providing regular updated information to family members which helped ease their anxieties. We were told that staff had made efforts to provide the family with information on mental illness and medication that supported family members to gain a better understand and knowledge, specifically in relation to how this impacted on their loved one.

The family member was of the view that their loved one's mental and physical health had improved since admission to the IPCU. We were pleased to hear from the relative that their loved ones' cultural needs were recognised and appropriately supported.

We spoke with various staff and heard that they were happy in their role and felt supported by the ward management team. We heard there had been some changes to the staff group however, we were also pleased to hear that the staff group had a mix of experienced and newly qualified staff. Staff told us they valued new perspectives and approaches brought by recently qualified staff and students, as these supported ongoing learning and skill development across the team.

Staff we spoke with told us that it was becoming increasingly difficult to move individuals from IPCU to acute wards, due to the ongoing shortage of available beds in acute mental health settings. Some staff expressed concern that individuals were remaining in the IPCU longer than clinically necessary, resulting in the continued imposed higher levels of restriction. We shared these concerns and discussed them with the SCN, who informed us that bed usage was reviewed during daily bed flow meetings, and that senior managers in NHS Lothian had been made aware of the situation.

Staff told us that the level of acuity on the ward remained high, which at times made the working environment challenging. However, we were pleased to hear that ongoing support was in place for staff, including reflective practice sessions, supervision, and regular staff meetings.

Care, treatment, support, and participation

Person centred care plans

NHS Lothian had implemented a new person-centred care plan on 30 April 2025. The new person-centred care plans we reviewed on TRAKCare had various headings, for example: mental health, stress and distress, activities of daily living, legislation, substance misuse, physical health, care and family involvement and activity.

The SCN told us that following the introduction of the new care plans, staff had been actively engaged in updating existing plans and completing new ones for individuals recently admitted to the IPCU. The service has recognised that further training is required to ensure all care plans are completed to a consistently high standard and we were advised that a training programme was in place to support staff in

developing the knowledge and skills required to complete high-quality, person-centred care plans.

The care plans we 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 achieve these. These care plans were individualised, goal focussed, person-centred and adopted a strengths-based and holistic approach. Other care plans lacked this level of detail, with some sections incomplete. We acknowledge that the new care plan documentation was still in its early stages of implementation and we look forward to seeing an improvement across all care plans on our next visit.

We were unable to see evidence of regular care plan reviews taking place. This was raised with the SCN on the day, who told us that a new review template had recently been introduced in line with the implementation of the new person-centred care plan. We were informed that the review process would be fully embedded once staff training on the new person-centred care plans had been completed. We look forward to seeing this during our next visit.

We saw that physical health care needs were being addressed and followed up appropriately by the advanced medical practitioner (AMP) and core trainee medics. We were pleased to see a clear focus on physical health, with input from a range of allied health professionals contributing to the overall care and treatment. The medical reviews completed were of a high standard, and those undertaken by both core trainees and AMPs demonstrated comprehensive, personalised documentation with evidence of forward planning in care and treatment.

We were pleased to find that discharge planning and dates were discussed and set from the point of admission. We heard that on some occasions individuals had been discharged directly from the IPCU, primarily due to a lack of available acute mental health beds and to avoid unnecessarily delays. We saw that to support discharge planning, the MDT liaised with various professionals and services such as housing, social work, Department of Work and Pensions (DWP) and third sector providers. Discussions regarding discharge took place at MDT meetings and during senior medical reviews. We were pleased to find that all members of the MDT were involved in the discussion and decision making to support discharge planning.

In our previous report, we highlighted inconsistencies in the quality of information recorded in risk assessments. The service advised us that following on from that visit, an audit of all risk assessments would be undertaken to ensure greater consistency and accuracy in the documentation. We were pleased to see an improvement in the overall quality of risk assessments during the visit. The risk assessments we reviewed included clear information on current risks, along with safety plans in place to manage and support those risks. Historical risk information

had been appropriately condensed, allowing the current, relevant risks to be clearly identified.

We found that in addition to the risk assessments, care plans on violence and aggression and pass plans had been completed. The information recorded in these documents were of high quality and evidenced the risk assessment.

Care records

The care records were 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**.**

Our review of the care records noted that there were high levels of clinical acuity. We found documented in the records regular incidents of acuity of mental ill health, violence and aggression that required high levels of input from all members of the MDT.

The care records we reviewed included comprehensive and individualised information from all members of the MDT. It was evident from reading the care records how individuals spent their day, what members of the MDT had interventions with them and the outcome of interventions.

The information recorded was person-centred, strengths based, outcome and goal focussed and included forward planning. This strengths-based approach was also evident during more challenging circumstances, such as following incidents of aggression. The care records reviewed evidenced a holistic and trauma informed approach to the care of individuals in Blackford ward.

There was evidence of frequent one-to-one interactions between individuals and all members of the MDT. The individuals we spoke with told us that they met with nursing staff and other members of the MDT regularly. The one-to-one interactions we reviewed were comprehensive. We liked the use of 'how are you' and 'what matters to me' in the one-to-one records, as it evidenced objective conversations with individuals that gave them the opportunity to their provide views in relation to their care and treatment, promoting a rights-based model of care.

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

Multidisciplinary team (MDT)

The unit had a broad range of disciplines either based there or accessible to them. In addition to medical and nursing staff, the MDT was made up of two activity co-ordinators, occupational therapy (OT), AMP, pharmacy and an art psychotherapist. There was no psychology based in the ward. We were told that when psychology input was required, a referral was made to psychological services.

We also heard that the ward had regular input from MHO's and spiritual care services.

The MDT met weekly in the ward. In attendance at the meeting were medical staff, nursing staff, pharmacy and at times, OT and the art psychotherapist. Members of the MDT who were unable to attend the meeting recorded information on the MDT recording template prior to the meeting. The MDT meeting was recorded on TRAKCare, on the mental health structured MDT template.

We found the MDT meeting records were of an excellent standard. The information recorded in the MDT records was comprehensive and contained detailed recording of the discussion, decisions and forward planning that took place. We were pleased to find that in addition to discussions on an individual's mental health, the MDT focussed on physical health, legal status, rights-based care, socio-economic and cultural factors. This promoted a holistic and trauma informed approach to the individual's care. It was evident that everyone in the MDT was involved in the care of the individuals in Blackford Ward and committed to adopting a holistic approach to care and treatment.

We noted from the care records that the consultant psychiatrist met with the individuals at least once a week to discuss their care and treatment plan, the outcome of the meeting and the decisions that were made.

We also saw that during one-to-one interactions with nursing staff, individuals were asked for their views on their care plan, which was reflected in the MDT discussions. Individuals that we spoke with were happy with this arrangement, reporting that they felt involved in discussions and decision made regarding their care and treatment.

In relation to carer/relative involvement, we noted that when family were involved with an individual's care, separate family meetings were arranged.

Use of mental health and incapacity legislation

On the day of the visit, nine people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). We were able to locate all documentation relating to the person's detention on TRAKCare.

During our visit in October 2023, the Commission raised concerns regarding delays in the allocation of MHOs for individuals subject to short-term detention certificates (STDCs) and made a recommendation that a pathway be developed in partnership with social work to support timely allocation. On our return visit in October 2024, we were pleased to note progress with all detained individuals having an allocated MHO. However, we were disappointed to observe a subsequent deterioration in this practice. In follow-up discussions, the local authority attributed the delays to ongoing

MHO staffing challenges. We were reassured to learn that new MHOs had recently been appointed to address the issues.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed. We reviewed the prescribing for all individuals, as well as authorisation of treatment for those subject to the Mental Health Act and found the documentation reviewed was up to date and correctly authorised treatment.

Medication was recorded on the electronic prescribing system HeMPA (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.

We suggested during our last visit 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. While we found the service had actioned the suggestion and there was a folder in the dispensary, the T2/3 documentation was not up to date. We raised concerns about the current process with the SCN and consultant psychiatrist and offered suggestions to support improvements so that nursing staff can confirm what is authorised before dispensing medication.

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 it easy to locate all documentation recorded on TRAKCare.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland), 2000 Act (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 the two section 47 certificates completed and found that the certificates were appropriately completed and compliant with the legal requirements.

Rights and restrictions

Blackford Ward continues to operate a locked door, commensurate with the level of risk identified with those on the ward.

The majority of the individuals we met with had good knowledge of their rights. We saw that each detained individual had received a letter from medical records following detention under the Mental Health Act that included information on their detained status and their rights in relation to this. We found that most individuals had legal representation and support from advocacy.

We noted that some individuals had exercised their rights and had appealed the legal order they were subject to.

We were pleased to see ongoing efforts to promote a proactive, rights-based approach to care in the ward. An information board was displayed at the entrance to the ward and in the games room, providing clear and accessible information on the Mental Health Act, the criteria for various mental health orders, individuals' rights when subject to these orders, and how to exercise those rights. In addition to written materials, the board featured QR codes linking to the Mental Welfare Commission's website, supporting individuals to access further rights-based information independently.

We heard from some individuals that they found the levels of restriction in the IPCU challenging at times, particularly in relation to time off the ward. However, we were pleased to hear that support was available to help individuals understand these restrictions. The art psychotherapist and community meetings played a key role in facilitating these discussions, helping individuals understand the reasons for restrictions and supporting individuals to access further rights-based information independently.

Blackford Ward had a high dependency unit (HDU), which was not being used on the day of the visit. We heard that the use of the HDU had significantly reduced. In reviewing the records, we were able to see when alternative measures had been implemented by the MDT to manage increased levels of stress and distress. These included the use of bedroom seclusion, which provided a less restrictive and person-centred approach. However, there were still occasions when seclusion in the HDU was required to support individuals who were displaying extreme stress and distress.

On the day of the visit, four individuals were subject to continuous intervention (CI). Where CI was in place, it was proportionate to the assessed level of risk and need. We observed that individuals subject to CI were, when appropriate, offered opportunities to engage in therapeutic interventions that promoted communication,

engagement, and recovery. CIs were regularly reviewed by the MDT, to review their effectiveness and ensure a person-centred approach to care.

The ward held regular community meetings called 'The Blackford Blether' facilitated by the OT and activity co-ordinator. We were able to see a copy of the minute of the meeting and saw various discussions taking place and feedback from individuals on what was good in the ward, areas of improvement and feedback provided by the individuals who attended. The meeting also included a focus on the weekly ward mantra, which on this occasion was 'kindness, patience, understanding and respect'.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We did not find any advance statements in the care files reviewed. Some of the individuals we met with were aware of advance statements however, had chosen not to complete one. Other individuals were unaware of advance statements. It was evident from review of the individual's files and during discussion with some of the individuals that they were not at a point in their recovery to be able to make decisions regarding their future care and treatment.

Advocacy services were provided by 'Advocard'. We were told that they had regular input to the ward, attended the ward on request and provided a good service to individuals who wished to engage with them. We were pleased that the individuals we met with and reviewed on the day of the visit either had or had been offered advocacy support.

The Royal Edinburgh Hospital (REH) has a patient council group that offers collective advocacy and drop-in sessions in Blackford Ward on occasion.

The Commission has developed *Rights in Mind.*[1] 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

Blackford Ward had two activity co-ordinators. We were pleased to hear that activity and occupation is offered to individuals seven days a week. Although activity and occupation in the ward was mainly provided by the activities co-ordinators, nursing staff, OT, the art psychotherapist and volunteers also supported activity on the ward.

A weekly timetable was displayed in the ward noting activities on offer. The activities available included art psychotherapy, therapet session, fitness club, jewellery

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

making, gardening group, table tennis, board games, quizzes, spa session and music/karaoke session. We heard that some individuals attended the HIVE day service, an activity centre situated in the grounds of the hospital which provided activities such as clay modelling, library sessions and various crafts. We saw that a music festival, HIVEStock was being arranged, offering an opportunity for individuals to listen to bands and enjoy the BBQ and many stalls on offer.

The individuals we met with spoke very positively and were complimentary about the activities and occupation available to them. Many of the individuals commented that there was a wide range of activities available and that they were able to engage in activities that they liked and had an interest in. We also heard and saw that activities supported skill development such as cooking sessions with the OT as well as areas including road safety and money management.

The physical environment

Blackford Ward is a mixed-sex, IPCU; the physical environment must be managed to support individuals safely, while enabling them to feel safe and comfortable in the ward setting. The bedroom areas in the ward were divided into a male and female areas. Each bedroom had en-suite facilities and we noted that individuals could personalise their bedroom if they chose too.

The cleanliness of the ward was of a high standard. Since our last visit, the ward had been repainted, creating a brighter and more spacious environment. However, some areas still appeared clinical and would benefit from the addition of soft furnishings and artwork to promote a more therapeutic environment. We recognise the challenges in balancing safety with creating a more welcoming environment, particularly in an IPCU setting. During our visit, we discussed this with the SCN, who told us that some artwork and information boards had not yet been placed back on the walls following the recent painting and were told that work would be prioritised in order to reduce the clinical feel of the ward.

The ward has a range of spaces available for individuals to use, including male and female lounges, an art room, a games room and a dining area. A PlayStation and karaoke machine was available in the games room which made the room very popular with individuals and most tended to congregate and spend time in this area.

We saw that the ward required some repairs; for example, one of the bedrooms was missing a door, and one of the TVs was broken. We were informed that this damage had occurred during incidents involving individuals experiencing extreme stress and distress. The repairs had been reported to the REH estates department, and it was anticipated that they would be completed in a timely manner.

The ward had a therapy kitchen, although we were told that this was not used due to concerns raised in relation to safety issues. During our previous visit, we were told

that the use of this space was under review, with consideration being given to how it could be utilised to benefit individuals on Blackford Ward. We were advised that no progress had been made regarding a decision on the future use of the room. However, we were encouraged to hear that an alternative OT assessment kitchen was available elsewhere on the REH site, should a kitchen-based assessment be required

There was a courtyard garden area that was easy for individuals to access and they could do so throughout the day and until late evening.

Any other comments

We were pleased to hear that the service was actively engaged with the Scottish IPCU Network and working towards accreditation through the Quality Network for Psychiatric Intensive Care Units (QNPICU), managed by the Royal College of Psychiatrists.

Summary of recommendations

The Commission made no recommendations; therefore, no response is required. We will however seek confirmation from the service on how this report will be shared with staff, the individuals in the service, and the relatives/carers that are involved.

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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