Mental Welfare Commission for Scotland

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

Date of visit: 1 October 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

Merchiston Ward is a 16-bedded, male adult acute psychiatric admission ward in Royal Edinburgh Hospital (REH) with a catchment area for the southwest and southeast areas of Edinburgh. On the day of the visit, the bed capacity had been increased to 17 beds with the use of one contingency bed, located in the quiet room. We were told the use of contingency beds had continued over the past 12 months following our last visit to the ward.

We last visited this service in September 2024 and made five recommendations, including those around person-centred care planning while encouraging and inviting individuals to participate in their care and treatment, risk assessment and risk management, including the need to accurately record specific information that also included positive risk strategies. Lastly, we were aware individuals were admitted to the ward and were accommodated in rooms that were designed for communal activities or quiet spaces for individuals to relax in. We were concerned those rooms were not appropriate and recommended that all individuals admitted to Merchiston Ward should be provided with bedrooms that had ensuite facilities.

We received a detailed action plan from the service with actions for each recommendation and specific timescales.

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. This visit to Merchiston Ward was unannounced and while this did not offer the opportunity to meet with relatives and carers, we advised the ward-based team we would be happy to make contact with relatives post-visit should this be requested.

During our visit, we had the opportunity to meet with several members of the extended multidisciplinary team (MDT) including nursing staff, psychology, occupational therapy (OT), arts psychotherapy, and the hospital discharge co-ordinator for adult services.

Additionally, we met with nursing students who were on placement and who were enthusiastic to share their learning experiences on Merchiston Ward.

Furthermore, we also had the opportunity to meet with the senior leadership team for adult inpatient services to share our observations and reflections on the visit.

Commission visitors

Anne Buchanan, nursing officer

Lesley Paterson, senior manager (practitioners)

Kathleen Liddell, social work officer

What people told us and what we found

Of the individuals we had the opportunity to meet in person, they were largely positive about their inpatient experience. They discussed with us their regular one-to-one meetings with nursing staff, individual and group art/music psychotherapy and engagement with the ward's OTs which they considered beneficial in their recovery.

For others, having the opportunity to work with psychology had been a new experience however, one which was considered important for their understanding of themselves and their mental ill-health.

We had an opportunity to meet with several members of the MDT; we met with them individually and we heard a clear theme that working with individuals admitted to Merchiston Ward was a positive experience. All staff we spoke with felt they had a common goal and worked collaboratively to provide positive experiences for people admitted to the ward.

For nursing students on placement, they too had positive views of their experience however, they recognised having a greater number of students allocated to this placement had meant specific learning opportunities were not always possible. Nevertheless, their mentors were able to provide education and relevant experience to ensure they had felt involved in the day-to-day activities both in the ward and the hospital community.

Our last visit to Merchiston Ward in September 2024 identified several areas where individuals admitted to the ward had not felt involved with participating in their care planning. Unfortunately, this view was again shared with the visiting team. Individuals we spoke to were not aware of their care plans or whether they had been asked for their opinions in relation to the goals for their admission to hospital, what was important to them and how the clinical team could support their recovery.

We were told those specific questions were not routinely asked and while individuals had felt their inpatient experience had been positive, they were not always confident about the exact details of their care journey, and this included discharge planning.

Care, treatment, support, and participation

As with our previous visit to Merchiston Ward, we were keen to review care records as that activity allowed the visiting team to determine whether progress had been achieved in relation to previous recommendations. We had made recommendations that specifically looked at participation, rights-based care and working positively with risk.

We saw the greatest improvements in relation to risk assessments and working with individuals to consider how risks identified could be managed, while inviting the

individual to work in partnership with the ward-based team. We were informed the new 'person-centred care plan' tool was now embedded in the electronic record keeping system, TrakCare. However, during the review of individuals' care records we were unable to find care plans that would be considered person-centred.

The lack of information specifically gathered from individuals was apparent, their views and opinions which we would expect to be included in their care plans was not incorporated therefore it was difficult to determine whether individuals were invited to participate.

Recommendation 1:
Managers must ensure that individuals are fully involved in each stage of their recovery and that care plans are person-centred, reflect care needs and that individuals are aware of the clear interventions and care goals they are working towards to enable recovery.

We were pleased to have found progress with assessing and managing risk. However, we could not see where any information contained in the risk assessments had been incorporated into, or where any element of enquiry had directly influenced person-centred care planning. This was disappointing as we were informed inpatient services had been supported by practice educators in their attempts to improve nursing staff's understanding and implementation of person-centred care planning.

Assessing an individual's progress in terms of their recovery would be determined by regular reviews of their care plans, and when goals had been achieved, care plans would be amended to reflect this. Unfortunately, as care plans were not consistently person-centred nor reviewed regularly it was difficult to determine when an individual had achieved progress towards recovery and how this had been supported and by whom.

Recommendation 2:
Managers should carry out an audit of care plans to ensure all individuals admitted to Merchiston Ward are provided with documented evidence of how care is to be delivered and by whom.

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.

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

Care records

Information on individuals' care and treatment was held electronically on TrakCare. We found this electronic record system easy to navigate. We were pleased to find all staff input information onto TrakCare, including allied health professionals (AHPs), specifically OT, arts psychotherapy and psychology.

Daily continuation notes were captured using a 'canned text' framework that provided several areas of focus including mental health and well-being, activities, daily risk assessment and medication. On our last visit to Merchiston Ward, we felt that the canned text framework provided valuable information and reflected a detailed account of individuals' presentation throughout the day. While the canned text framework was still used, it no longer appeared to contain this detailed daily update information on clinical presentation. We were told this was captured in the person-centred care plan record. We had found and heard during our previous visits that daily updates were essential, particularly for visiting professionals, including bank nurses. We thought that this may have had the potential for missed communication and brought this to the attention for nursing staff who agreed that having to access various parts of the records posed a potential risk.

Where we saw evidence of one-to-one interactions between individuals and AHPs, there was a richness of detailed narrative. There was both a subjective and objective view and this allowed the reader to appreciate how an individual's mental health and well-being was at the time of the therapeutic activity. Those engagements were shown to be meaningful and provided an opportunity for individuals to explore what was important to them in relation to their recovery.

Over the past four months the service had introduced two discharge co-ordinators to specifically work with and support individuals to leave hospital. Their role was to engage with inpatient and community services to help plan and coordinate discharges from hospital-based care. While those roles were still in their infancy, we were informed they have been considered valuable in the services attempts to ensure individuals who are admitted to hospital have discharges that are arranged and planned to meet individuals' support needs.

We were provided with an additional update from the senior leadership team in that the discharge team will benefit from having social workers joining their team. There was a view that with additional resources, the co-ordinators will increase their capacity to engage with individuals, ward-based teams and community staff to ensure all discharges from the hospital are successful and sustainable. Furthermore, having dedicated staff to support discharge pathways will allow ward-based nursing staff to concentrate their efforts on the day-to-day care for individuals and support for relatives.

Multidisciplinary team (MDT)
Merchiston Ward befitted from a broad range of AHPs that also included art psychotherapist and psychology. Nursing staff informed us they had also benefitted from informal education from members of the MDT who had supported staff to improve their knowledge, skills and understanding of working with adults who by virtue of their childhood experiences or trauma experienced as adults required staff to consider care and treatment through a trauma informed lens.

We were told by all the AHPs we met with that they had felt very much part of a cohesive ward-based team and their own professional input had been valued by the service.

Where individuals received input from AHPs we saw clear identification of need through various assessment methods, goals setting and progress through regular reviews. We would suggest that nursing staff consider adopting a similar approach that draws on AHP practices to ensure that person-centred care remains central to nurses' daily practice.

Each consultant psychiatrist held a weekly MDT meeting. In attendance at those meetings were medical staff, nursing staff and on occasion, AHPs including psychology and arts psychotherapy.

We reviewed MDT meetings minutes which were held electronically on a 'mental health structured ward round' template. The template had specific areas of focus to consider, for example mental health and physical well-being, medication management and concordance, authorising treatment in relation to the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) and updates from AHPs.

Furthermore, discussion in relation to discharge planning and identified goals to enable a date for discharge to be agreed. The template offered an opportunity to ensure all areas that could support an individual's progress and recovery were discussed and explored. We saw the template was not always fully completed, therefore having up to date information was compromised and this included important areas, including discharge planning and the Mental Health Act.

Recommendation 3:
Managers including senior medical staff should ensure that MDT weekly meetings are recorded accurately on the template designed to capture all relevant information concerning an individual's progress in Merchiston Ward.

Use of mental health and incapacity legislation

On the day of the visit, 12 people were detained under the Mental Health Act. All paperwork relating to the Mental Health Act was in order.

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

We reviewed the prescribing of medications and treatments for all individuals as well as the authorising of treatment for those subject to the Mental Health Act. Medication was recorded on the hospital electronic prescribing and medication administration system 'HEPMA' T2 and T3 certificates authorising treatment were stored separately on TrakCare.

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

During our review we noted three individuals were receiving treatment not legally authorised either by a T2 or T3 certificate. We brought this to the attention of the senior leadership team and requested an urgent review of these cases and that remedial action is taken as necessary.

Recommendation 4:
Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised where required, and a system of regular auditing compliance with this should be put in place.

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 this stored on TrakCare.

For those people that were subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), we were unable to find copies of their welfare guardianship paperwork including the specific powers granted by the Sherriff and whether those had been delegated to the ward-based care team. If those powers had been delegated, we could not locate when this discussion had been held, with whom and how agreement had been made to ensure all delegated powers could be met.

Recommendation 5:
Managers should ensure that all individuals who are subject to AWI Act have their legal paperwork correctly stored in their electronic care records and that any discussion regarding the delegation of welfare powers are clearly documented.

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 were concerned to find that for one individual, who required a significant input for their physical health, that a section 47 certificate and accompanying treatment plan was not in place.

Recommendation 6:
Managers should ensure that where a person lacks capacity in relation to decisions about medical treatment, section 47 certificates, and where necessary, treatment plans must be completed in accordance with the AWI Act Code of Practice (3rd ed.) and cover all relevant medical treatment the individual is receiving.

Rights and restrictions

Merchiston Ward operated a locked door, commensurate with the level of risk identified with the individual group. The ward had a locked door policy that was displayed at the entrance door.

The individuals we met with during our visit had a mixed understanding of their detained status and their rights under the Mental Health Act. We noted that the new person-centred care planning tool had an option to include interventions that allowed staff to support individuals with their understanding of their detained or informal status.

Unfortunately, from the care plans we reviewed it was not always clear whether individuals knew about their detained status and right to both legal representation and advocacy services.

Recommendation 7:
Managers should ensure person-centred care plans that are required for people who are subject to the Mental Health Act legislation are in place to support their understanding of their detained status and of their right to legal and advocacy representation.

We identified individuals who, following assessment, were deemed to require an enhanced level of observation. This level of observation, known as 'continuous

intervention' involves nursing staff maintaining constant, therapeutic presence with the individual due to an increased risk of harm to themselves or others.

We reviewed the care plans developed to support this intervention and found them to be detailed and regularly reviewed. However, where individuals were assessed as requiring this level of observation and being cared for informally i.e. not detained under the Mental Health Act, it was unclear whether their informed consent had been obtained. We sought clarification from the ward-based team regarding how they document and evidence communication with informal patients who are placed on a higher level of observation.

It was not clear through our discussion whether the ward-based team had enquired with individuals, therefore, could not evidence that they had always sought informed consent.

Recommendation 8:
Managers should ensure the ward based clinical team seek informed consent for levels of observation that may be considered intrusive and, that consent is regularly assessed to ensure rights-based care is being delivered.

We advised the senior leadership team to ensure all staff were adopting a rights-based care approach to care and treatment. This would include staff having regular follow-up discussion with individuals regarding their rights, to ensure rights-based care was actively and consistently promoted.

Sections 281 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 this and where restrictions are introduced, it is important that the principle of least restriction is applied. We reviewed the documentation for individuals who had specific restrictions in place and found all paperwork in order.

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

People admitted to Merchiston Ward were offered a range of therapeutic and recreational activity.

In terms of therapeutic engagement, we were told individuals were invited to participate with either one-to-one or group art/music psychotherapy. Psychology also provided sessions for individuals while also providing opportunities for team

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

psychological formulations. This was welcomed by the team as part of an ethos to provide trauma informed care and treatment. It was recognised that early childhood experiences had a life-long impact and by exploring those experiences with individuals and supporting their recovery had a positive impact for improving relationships with staff and friendship groups.

Individuals also benefitted from having regular input from OT who undertook formal functional assessments along with a more informal approach to group work.

The ward activities co-ordinator had been a mainstay for Merchiston Ward and was able to adapt their daily activities schedule to meet individuals' likes and preferences. With local and community connections they were able to ensure individuals admitted to the ward had opportunities to either have one-to-one activities or if agreeable, would be encouraged to attend group activities.

We asked the senior leadership team to remind ward-based staff that it is helpful to document in care records whether an individual had engaged in reactional activities and to seek an individual's subjective view of their participation. We heard that for some people they felt "bored" therefore, seeking their views of recreational activities currently available may be helpful in shaping the activity provision.

The physical environment

Merchiston Ward was a 16-bedded ward with communal space for socialising which also doubles up for dining space. There was also a dedicated space for activities which was used for art psychotherapy and OT sessions.

While the ward was designed for everyone to have their own bedroom with en-suite facilities, we were disappointed to see the ward's quiet room was occupied and considered as an additional bedroom or "surge bed". We were informed the quiet room had largely been used as a 'bedroom' since our last visit to Merchiston Ward.

The room did not offer washing facilities, it provided limited privacy and importantly was not designed to be ligature proof therefore individuals admitted to the ward and having to be accommodated in this room were required to be placed on enhanced observation, regardless of whether they have been assessed as an immediate risk of harm.

Our position remains the same as highlighted during our previous visits to the adult acute admission wards across the REH site in that we do not believe individuals admitted to hospital due to the severity of their mental illness and presentation should be accommodated in rooms not designed to be bedrooms. We are also concerned, people who do not require an enhanced level of observation are having restrictions placed upon them that are only required due to them being placed in an

unsuitable environment and would not be considered necessary should they have the advantage of being in an appropriate bedroom.

We were informed by the senior leadership team this practice had continued due to the increasing numbers of people requiring inpatient care and capacity demands across the service. We were told there was an intention to be part of a review of both inpatient and community mental health services which will consider a service model that will meet the needs of individuals who require inpatient care and will improve admission and discharge pathways.

Encouragingly we were also told that there was a plan in place to reduce the number of ‘surge beds’ across the REH site by one per week until there were none in use. We will continue to liaise with senior managers to hear how this progresses.

Summary of recommendations

Recommendation 1:
Managers must ensure that individuals are fully involved in each stage of their recovery and that care plans are person-centred, reflect care needs and that individuals are aware of the clear interventions and care goals, they are working towards to enable recovery.

Recommendation 2:
Managers should carry out an audit of care plans to ensure all individuals admitted to Merchiston Ward are provided with documented evidence of how care is to be delivered and by whom.

Recommendation 3:
Managers including senior medical staff should ensure that MDT weekly meetings are recorded accurately on the template designed to capture all relevant information concerning an individual's progress in Merchiston Ward.

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Managers should ensure that all individuals who are subject to AWI Act have their legal paperwork correctly stored in their electronic care records and that any discussion regarding the delegation of welfare powers are clearly documented.

Recommendation 6:
Managers should ensure that where a person lacks capacity in relation to decisions about medical treatment, section 47 certificates, and where necessary, treatment plans must be completed in accordance with the AWI Act Code of Practice (3rd ed.) and cover all relevant medical treatment the individual is receiving.

Recommendation 7:
Managers should ensure person-centred care plans that are required for people who are subject to the Mental Health Act legislation are in place to support their understanding of their detained status and of their right to legal and advocacy representation.

Recommendation 8:
Managers should ensure the ward based clinical team seek informed consent for levels of observation that may be considered intrusive and, that consent is regularly assessed to ensure rights-based care is being delivered.

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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