**Mental Welfare Commission for Scotland**

**Report on unannounced visit to:**
The Royal Edinburgh Hospital, Hermitage Ward, Morningside Place, Edinburgh, EH10 5HP

**Date of visit:** 10 June 2026

**Our local visits detail our findings from the day we visited; they are not inspections.** Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

## Where we visited

Hermitage Ward is the mixed-sex, adult acute psychiatric ward for individuals primarily residing in the East and Mid Lothian areas of NHS Lothian. We heard some of the beds are occupied by individuals from the City of Edinburgh area for a variety of reasons, including individual preference of not wanting to be admitted to a single-sex ward or resulting from risk assessment.

Hermitage Ward has 16 beds. On the day of our visit, we were told that 11 individuals from other adult acute wards in the Royal Edinburgh Hospital (REH) were in Hermitage Ward and other individuals that met the criteria for Hermitage Ward were receiving care and treatment in other wards in the REH. We were told that one individuals' discharge was delayed due to them awaiting provision of a specialist service and community care services.

We last visited this service on 17 November 2025 and made recommendations about improving individuals involvement in care planning and decision-making, strengthening the quality and person-centred nature of care plans and risk assessments, ensuring equitable access to psychological therapies and regular multidisciplinary reviews, improving compliance with legal safeguards and local Adult Support and Protection procedures, and enhancing the ward environment by providing dedicated therapeutic space and single-bedroom accommodation.

In response to our previous recommendations, the service developed an action plan which included refresher training for staff on collaborative care planning, person-centred documentation, risk formulation and Adult Support and Protection. There was to be strengthened audit and governance arrangements through monthly audits, with supervision and spot checks. Improvements were planned to multidisciplinary team (MDT) working and structured ward round documentation, with increased access to psychological services following recruitment. There was to be enhanced monitoring of legal documentation relating to consent to treatment and a reinforcement of processes to ensure the individual's involvement in care planning and decision-making was consistently recorded in the clinical records.

On the day of this visit we wanted to meet with individuals and relatives/carers to hear how care and treatment was being provided on the ward and also follow up on the previous recommendations.

### Who we met with

We met with, and reviewed the care of nine people, six on whom we met with in person. We also met with one relative.

We spoke with the senior charge nurse (SCN), psychologist, recreational nurse, other nursing staff, clinical support workers and student nurses.

Following the visit, we contacted the mental health officer (MHO) teams from East and Mid Lothian, as well as the City of Edinburgh.  We also contacted CAPS advocacy service and AdvoCard advocacy service.

## Commission visitors

Kathleen Liddell, social work officer

Tracey Ferguson, social work officer

Mary Leroy, nursing officer

## What people told us and what we found

### Comments from individuals

The feedback from individuals on the day of the visit was mainly positive. We heard that staff were “helpful and approachable”. One individual said, “it’s the best care I’ve ever received”. We heard that staffing levels were good and staff were readily available for one-to-one discussions, which were actively promoted. Those who had received one-to-one support described it as beneficial and supportive to their recovery.

Most individuals we spoke with were aware of their care plan and reported that they felt involved in its development. Individuals also told us that they were encouraged to participate in discussions and decisions regarding their care, treatment and support, and that their views were listened to by staff. This was encouraging to hear given the Commission made a recommendation in the previous report relating to meaningful participation in care planning and decision-making.

Feedback from individuals suggested that the service has made positive progress in promoting involvement and shared decision-making. The Commission would like to see this involvement being continued and supported in practice, ensuring that it is appropriately recorded in the clinical record to demonstrate how individuals have participated in decisions about their care and treatment.

Most individuals we spoke with provided positive feedback about the range of activities available on Hermitage Ward. They spoke positively about the support provided by the recreational nurse and other members of the MDT, particularly the occupational therapist (OT) and music therapist. Individuals told us there was a good programme of regular ward-based activities available throughout the week, which they felt supported their therapeutic goals and recovery.

One individual expressed the view that there was a lack of activity. However, our review of the clinical records demonstrated that regular opportunities to participate in therapeutic activities were being offered. The records indicated that the individual's limited engagement reflected their current presentation rather than a lack of activity provision.

Most individuals told us they had regular contact with, and were reviewed by, their consultant psychiatrist; they described these meetings as positive experiences. Individuals reported feeling "listened to" and that their views were valued and considered when decisions were being made about their care and treatment. Some individuals were, however, uncertain about the roles of the different medical staff involved in their care. This occasionally led to frustration when their questions or requests could not be answered until there had been a discussion with the consultant psychiatrist. Our review of the clinical records identified evidence of regular reviews by a range of medical staff, with comprehensive and person-centred

documentation of assessments, clinical decision-making and the individuals' views being taken into account.

On the day of the visit, we discussed the different medical roles with the senior management team and suggested that consideration should be given to ensuring that individuals understood the roles of different members of the medical team and how decisions regarding their care are made.

Most individuals we spoke with raised concerns about the choice and quality of food provided on the ward. We discussed this with the SCN, who was aware of these concerns and advised us that they had been escalated to the senior management team. We were encouraged to hear that a nutritional working group had recently been established to review the menu across the Royal Edinburgh Hospital (REH), with the aim of improving the quality and choice of meals available to individuals.

**Comments from relatives**

We met with one relative during the visit, who provided very positive feedback about the care and support received. The relative told us that this was their first experience of a psychiatric ward and that staff had been welcoming, supportive and readily available to provide reassurance and answer any questions. The relative told us that this had helped to reduce their anxieties and enabled them to feel well supported throughout their loved one's admission.

The relative also told us that they felt appropriately involved in their loved one's care and that their views were listened to and valued by the staff team.

We saw that there was carers' information displayed at the entrance of the ward.

**Comments from staff**

The staff we met with spoke positively about working on Hermitage Ward and described feeling well supported by the ward management team. They told us there were good opportunities for training and career development, and that the SCN prioritised staff appraisals and regularly reviewed progress against individual objectives.

Staff reported that staffing levels had improved since the Commission's previous visit. They acknowledged that staffing availability continued to fluctuate depending on the clinical acuity of individuals on the ward and the requirement for continuous intervention (CI). We have since been advised that staffing levels are reviewed daily through weekday staffing huddles, informed by ward-based assessments of patient acuity and clinical need using the Safecare system. Established escalation processes are also available and staff are actively encouraged to utilise these where concerns arise. Staff described a supportive team culture and told us they were committed to delivering person-centred, trauma-informed care to support individuals' recovery.

## Care, treatment, support, and participation

We reviewed the care plans for six individuals. Four individuals had person-centred care plans in place however, two did not. We were concerned that one individual had been admitted to the ward for over a week without a completed care plan. We raised this with the clinical service manager on the day of the visit, who advised that all individuals should have a needs assessment and risk assessment completed within 48 hours of admission, followed by the development of a person-centred care plan. Feedback from the service has advised that initial risk assessments are expected to be completed within the first six hours of admission. An initial care plan should be in place within 24 hours, with a more comprehensive and detailed care plan completed within 48 hours.

In our previous report, we raised concerns that not all sections of the person-centred care plans had been completed. We highlighted that comprehensive care planning is essential in directing the care, treatment and interventions required to support individuals with acute mental illness. During this visit, we again found that only some sections of the care plans had been completed, with several essential sections left blank. We raised this issue with the senior management team and asked whether NHS Lothian had adopted a local approach whereby only selected sections of the care plan were completed. We were advised that this was not the case and that all sections of the care plan should be completed where relevant to the individual's assessed needs.

The quality of the completed care plans that we reviewed was mixed. We reviewed two care plans for individuals who had had extended admissions; these were of a high standard. They clearly documented the individual's goals, identified outcomes and detailed the nursing and MDT interventions required to support recovery. They demonstrated a person-centred approach and provided a clear understanding of the care, treatment and support being delivered by the MDT.

However, the other care plans that were reviewed lacked sufficient detail. In particular, sections of the care plan that focused on the identified goals, the planned interventions and the evaluation of progress were not consistently recorded, making it difficult to understand how the MDT intended to support individuals to achieve their recovery goals or which members of the MDT were responsible for delivering specific interventions. We would expect care plans to provide a comprehensive, person-centred record that clearly directs care, treatment and support, and be regularly reviewed to reflect individuals' changing needs.

We were pleased to note an improvement in individuals' awareness of, and participation in, their care planning. The feedback we received from individuals suggested they felt involved in discussions and decision-making regarding their care and treatment. While this was reflected well in some care plans, it was not consistently evidenced across all documentation. We would expect individuals'

participation in care planning and decision-making to be consistently recorded in their care plans, in line with the principle of participation.

We were unable to find evidence of regular or consistent reviews of care plans. Where reviews had taken place, they often lacked a summative evaluation of progress, the effectiveness of interventions or any changes required to support individuals in achieving their goals. We were encouraged to hear that the service is implementing the person-centred evaluation of care and treatment (PECAT) audit tool, which aims to strengthen the quality and consistency of care plan reviews.

We found that no individual had a completed care plan relating to discharge planning, including one individual whose discharge had been delayed. Although there was evidence in the clinical records of MDT discussions, liaison with community services and discharge planning activity, this information had not been reflected in the discharge planning section of the care plan. We would expect care plans on discharge planning to clearly record agreed actions, identified barriers to discharge and the responsibilities of those involved, providing a coordinated record of progress towards discharge.

**Recommendation 1:**
Managers should ensure that all care plans are fully completed, regularly reviewed and updated to reflect individuals' current needs. Care plan reviews should include a clear evaluation of progress, the effectiveness of interventions, any changes required to meet agreed goals and evidence of individuals' participation in care planning and decision-making.

We were pleased to find improvement in the quality of risk assessments since our previous visit. The majority of risk assessments recorded historical and current risks, protective factors, short and long-term risk management strategies and clear plans to support identified risks. Where individuals presented with more complex risks, we saw evidence of a MDT approach, including psychological risk formulation, which strengthened the assessment and management of risk.

We also found good evidence that physical health needs were routinely considered in care planning. Physical health monitoring was regularly undertaken and there was appropriate liaison with, and referral to, other healthcare professionals and services where required, demonstrating a holistic approach to individuals' care.

**Care records**
The care records were recorded on TRAKCare. Most entries were recorded using a pre-populated template aligned to the person-centred care plans, which supported consistency and continuity of care, treatment and support.

For individuals without completed care plans, information was recorded under alternative clinical headings in the electronic record.

Review of the clinical records demonstrated that individuals on Hermitage Ward had complex and acute mental health needs, requiring high levels of assessment, therapeutic engagement and multidisciplinary intervention.

Care records reviewed were predominantly comprehensive, individualised, good quality and recorded by a range of MDT members. The records provided a clear account of each individual's presentation, how they had spent their day, the interventions delivered by the MDT and the outcomes of those interventions. The information was person-centred, strengths-based and evidenced a therapeutic and recovery-focused approach to care**.** This was consistent with the feedback we received from individuals, who described staff as supportive, engaging and involving them in decisions about their care and treatment.

We were pleased to see regular reviews by senior medical staff, including consultant psychiatrists and other medical colleagues. These reviews were comprehensive and consistently recorded the individual's views, current presentation, clinical assessment, agreed care plan and required follow-up actions.

There was also clear evidence of regular input from all members of the MDT, reflecting a coordinated multidisciplinary approach to care.

Regular one-to-one therapeutic engagement was well evidenced throughout the records by all members of the MDT. These entries were comprehensive, personalised and strengths-based, demonstrating meaningful conversations about individuals' wellbeing, their views on care and treatment, and progress towards recovery goals. We also found examples of staff discussing care plans with individuals and reviewing any concerns or changes to their needs.

Where appropriate, the records included evidence of communication and involvement with families and carers, reflecting individuals' wishes and preferences regarding family participation in their care.

The Commission has published a good practice guide on care plans[1]. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

## Multidisciplinary team (MDT)

Hermitage Ward had access to a broad MDT, including nursing staff, consultant psychiatrists, psychology, OT, a recreational nurse, junior medical staff and music therapy.

As highlighted in our previous reports, the structure of the MDT remained more complex than other acute wards in the REH as the ward provided care for individuals from three health and social care partnerships (HSCPs).

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

We met with the ward psychologist during the visit. We heard that the psychology provision has remained in place and as we found it on our previous visit; we were pleased to hear that all individuals admitted to Hermitage Ward were able to access psychology input where clinically indicated. Psychology provided individual therapeutic work, contributed to MDT risk formulation and supported the MDT through consultation and reflective practice. We saw good examples of psychological assessment and formulation in the clinical records and risk assessments reviewed.

We also met briefly with the music therapist and heard that both individual and group music therapy sessions continued to be available. We were encouraged to hear that music therapy remained well integrated in the ward's therapeutic programme and contributed to individuals' recovery-focused care.

We contacted the local authority MHO teams to seek feedback on their experience of multidisciplinary working and discharge planning. We received feedback from one of the social work teams for the locality served by Hermitage Ward, who described positive collaborative working with the ward. They told us that there was a good understanding of individuals' care needs, that communication between community and inpatient services was effective and community teams remained actively involved throughout an admission and into the discharge planning.

Each consultant psychiatrist continued to hold a weekly MDT review for the individuals under their care. We reviewed several structured MDT records and found these to be generally comprehensive, where there was a recording of the discussion relating to an individuals' presentation, care, treatment and future plans. We also saw evidence that some individuals attended these meetings and were supported to participate in decisions about their care.

We found that the structure and attendance at MDT meetings continued to vary across consultant teams. We were, however, encouraged to find some progress since our previous visit. One consultant psychiatrist from another locality attended the ward with the wider MDT to review individuals in their care, demonstrating a more collaborative and coordinated approach to multidisciplinary decision-making.

Despite this improvement, attendance at MDT meetings remained inconsistent. While some individuals benefited from review by a full MDT, others were reviewed primarily by the consultant psychiatrist with limited involvement from other disciplines. Although we found good evidence throughout the clinical records of multidisciplinary working and communication between professionals, the formal MDT review process was not consistently applied across all teams.

We recognise that the organisational arrangements in Hermitage Ward present challenges due to the number of consultant teams and localities involved. However, these operational complexities should not impact upon an individual's right to receive coordinated multidisciplinary assessment, review and care planning.

We therefore remain of the view that all individuals should receive regular MDT review with appropriate multidisciplinary involvement and meaningful opportunities to participate in decisions about their care and treatment, so will repeat this recommendation for a third time.

**Recommendation 2:**
Managers must ensure that organisational arrangements in Hermitage Ward do not compromise individuals' rights to coordinated multidisciplinary assessment, review and care planning. All individuals must receive regular formal MDT review with appropriate multidisciplinary input and meaningful participation in decisions about their care and treatment.

## Use of mental health and incapacity legislation

On the day of the visit, 10 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 AWIA), including certificates around capacity to consent to treatment, were stored on TRAKCare and easily located.

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, including where ECT was being authorised. We found that one individual's T3 certificate had expired. We raised this with the SCN on the day of the visit, who advised that the consultant psychiatrist would be informed immediately to ensure the certificate was reviewed and appropriate action taken. We suggested an audit process was put in place to monitor Part 16 compliance and have since been advised that the pharmacy service have already initiated a quality improvement project focused on improving the accuracy and completion of T2 and T3 certificates, which includes ongoing monitoring and review.

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 easily located on TRAKCare.

During our review of the care records, we identified an individual where there were concerns that they may have experienced harm and where the MDT team had agreed that a referral should be made to the local authority under the Adult Support and Protection (Scotland) Act, 2007 (ASP). We were concerned that this action had not been progressed in an appropriate timeframe and raised this with staff during the visit.

During these discussions, staff advised that, as the individual was an inpatient and detained under the Mental Health Act, there was an assumption that this reduced the need to progress an ASP referral. We discussed the distinct purpose and statutory responsibilities of the two legislative frameworks, highlighting that detention under the Mental Health Act does not remove the Health Board's duties under ASP to report concerns about adults who may be at risk of harm and to cooperate with the local authority in any subsequent inquiries or investigations.

We were advised that most staff had completed adult support and protection e-learning, however we were concerned that the knowledge gained through training was not being implemented into practice.

Given that the Commission made a recommendation on this issue following our previous visit, we were disappointed to find a further example where safeguarding responsibilities had not been implemented in a timely manner. Delays in recognising and progressing ASP concerns have the potential to impact the timely safeguarding of adults who may be at risk of harm.

**Recommendation 3:**
Managers must ensure that staff understand and implement their statutory responsibilities under the Adult Support and Protection Act and local procedures. Where there are concerns that an adult may be at risk of harm, referrals to the local authority must be made promptly and in accordance with statutory duties, regardless of the individual's legal status under mental health or incapacity legislation.

## Rights and restrictions

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

We noted that a range of information on individuals' rights continued to be displayed and readily available throughout Hermitage Ward. In particular, the information board at the entrance to the ward provided clear and accessible information on the Mental Health Act, including the criteria for different mental health orders, individuals' rights when subject to these orders and how they could exercise those rights.

We were pleased to see that, in addition to written information, QR codes linked directly to the Commission's website, enabling individuals to access further rights-based information if they wished.

Most of the individuals we met with were aware of their rights, had access to either advocacy and legal representation and had been supported to exercise their right of appealing their detention.

We found evidence in the clinical records that medical staff regularly discussed individuals' rights, including their legal status, treatment and restrictions. However, we found fewer examples of rights-based discussions being recorded by other members of the MDT. We would expect all members of the MDT to support

individuals to understand and exercise their rights throughout their admission and to record relevant rights-based discussions in the clinical record.

We met with several individuals who had been admitted to the ward voluntarily and had agreed to the restrictions that were in place, primarily relating to escorted or unescorted pass arrangements. We were pleased to find that the individuals we spoke with understood the rationale for these restrictions, had consented to them and that this was clearly documented in their pass plans.

The ward held a weekly coffee morning, providing individuals with a regular and informal opportunity to share their views, raise concerns and make suggestions about the service. We were encouraged to see this as a means of promoting engagement and participation in the ward.

One individual was subject to continuous intervention (CI) on the day of our visit. We reviewed the CI care plan and found there was a clear rationale for the intervention, which was proportionate to the identified risks. The individual told us they understood why CI had been implemented and described it as beneficial, explaining that the therapeutic support and engagement provided by staff had helped them manage their distress.

We also found evidence in the daily care records of regular therapeutic engagement during periods of CI, including one-to-one support and meaningful activities. This reflected the principles set out in NHS Lothian's continuous intervention standard operating procedure (SOP), which promoted CI as a therapeutic intervention focused on engagement, recovery and least restrictive practice, rather than observation alone.

However, we found that the CI care plan did not fully reflect the requirements of the SOP. The care plan lacked sufficient detail regarding the specific therapeutic interventions to be provided, the contribution expected from members of the MDT and the planned review arrangements. While hourly CI records were in place, the quality of recording varied, with some entries providing a comprehensive account of the individual's presentation and therapeutic engagement and others containing only limited information. We would expect the CI care plan and associated records to provide a clear and consistent account of the therapeutic interventions being delivered, the individual's response to these interventions and the ongoing review of the necessity and effectiveness of CI.

**Recommendation 4:**
Managers should ensure that continuous intervention (CI) care plans and associated documentation are fully aligned with the NHS Lothian continuous intervention standard operating procedure. Care plans should clearly record the rationale for CI, therapeutic aims, multidisciplinary interventions, planned review arrangements, criteria for reducing or ending CI and the individual's views. Managers should implement a regular audit process to provide assurance that CI documentation is

completed consistently and accurately reflects the therapeutic care and review being provided.

Sections 281 to 286 of the Mental Health Act provide a framework for placing restrictions on certain detained individuals. Where an individual is subject to specified person provisions, it is important that any restrictions are lawful, proportionate and applied in accordance with the principle of least restriction.

On the day of the visit, we were advised that one individual was subject to specified person restrictions. We reviewed the documentation and found that the specified person authority had expired. Despite this, both staff and the individual believed that the restrictions remained in place. We raised this matter with the SCN on the day of the visit, who advised that the consultant psychiatrist would be informed immediately so that the individual's legal status and any associated restrictions could be reviewed without delay. We also advised that the individual should be informed of the position and reminded of their rights.

Managers should consider MDT training in the application and use of specified persons. The Commission has produced good practice guidance on specified persons[2].

When we are reviewing care records, we look for copies of advance statements. The term 'advance statement' refers to written statements made under section 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 to promote advance statements.

We found that no individuals had an advance statement in place at the time of our visit. During discussions with individuals, some were aware of advance statements and had made an informed decision not to complete one, while others were unaware of them. From our review of the care records and discussions with individuals, it was evident that many were experiencing acute mental illness and were not at a stage in their recovery where they felt able to consider or make decisions about their future care and treatment.

We contacted CAPS and AdvoCard advocacy services to seek feedback on individuals' experiences of care and treatment in Hermitage Ward. Both services described positive working relationships with ward staff and continued to provide independent advocacy to support individuals to understand and exercise their rights, including supporting advance statements where requested.

Advocacy services told us that, while many individuals spoke positively about their care and treatment, there remained a recurring theme of some individuals feeling insufficiently involved in decisions regarding their care and treatment and being unclear about their care plan, medication and future plans. Advocacy services

[2] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512

advised that this uncertainty could be anxiety-provoking and frustrating for individuals. We also heard that some individuals experienced delays to agreed escorted pass arrangements due to staffing availability and that changes in the responsible medical officer during admission could affect individuals' experience of continuity of care.

The Commission has developed *Rights in Mind.*[3] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

## Activity and occupation

We heard and found evidence of a range of therapeutic and recreational activities available to individuals on Hermitage Ward. Individuals spoke positively about the activities on offer and described them as making an important contribution to their recovery, wellbeing and daily routine. We were encouraged to hear this feedback, as it demonstrated progress since our previous visit, when some individuals reported that activities did not always reflect their interests or occupational goals.

During the visit, we observed a range of activities taking place on the ward, including a clay modelling session facilitated by the OT, which individuals appeared to engage with and enjoy.

Activity provision was coordinated by the recreational nurse, with additional input from OT and music therapy. The recreational nurse advised that activities were available Monday to Friday and included both group and individual sessions. Individuals could also be supported to access activities outside the ward, including walks in the local community and attendance at The Hive, where they could participate in activities and socialise with others. A dedicated activity room was available on the ward for creative and therapeutic sessions, and volunteers, therapet, also contributed to the activity programme.

The recreational nurse told us that activity preferences were discussed regularly with individuals, including during a weekly coffee morning, and that activities could be adapted to meet individual needs through one-to-one or group work. We were encouraged to hear that there were plans to further strengthen person-centred activity planning by recording individuals' interests, goals and outcomes in their care plans.

We noted that an activity planner was displayed on the ward however, this was not fully up to date at the time of our visit. We also found that, although participation in activities was well evidenced in the daily care records, meaningful activity care plans were not consistently completed or regularly updated. We would expect everyone to have a completed and regularly reviewed meaningful activity care plan to support a more structured approach to documenting occupational goals, preferred activities

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

and progress. This would provide greater assurance that activity provision is planned, personalised and reviewed as part of the overall care planning process.

## The physical environment

Since our previous visit, we were encouraged to note a number of positive developments in the ward environment. The contingency bed had been closed, which has resulted in improved availability of space in the ward. Individuals described the ward as calm overall, although at times, it could be busy. They also reported that there was usually sufficient space to sit quietly when required. Commission staff observed that the ward environment on the day of the visit was calm and well organised.

The physical layout of the ward remained unchanged. The bedroom zones in the ward were divided into a male and female area. Each bedroom had en-suite facilities, and we were aware that individuals could personalise their bedroom if they chose to.

The main space used by individuals and staff was an open plan, communal TV/dining area. Individuals were able to use the kitchen area in the communal space to make drinks and have snacks. On the day of the visit, we saw individuals and staff congregating in this area, engaging in conversation and activity.

We observed improvements in the overall appearance and therapeutic feel of the environment. We were pleased to see that additional artwork had been introduced through NHS Lothian's Art Charity, which contributed to a more homely and therapeutic atmosphere. We also noted that recreational items, including a magnetic dart board and table tennis facilities, had been introduced, which individuals welcomed.

We observed the ward to be clean and well maintained. There was appropriate signage in place to support awareness of the no-smoking legislation in hospital grounds.

The courtyard garden remained accessible to individuals and was regularly used. We observed that the garden was somewhat overgrown at the time of our visit and would benefit from ongoing maintenance to improve its appearance and usability.

We were disappointed to note limited progress in relation to the development of more therapeutic quiet spaces in the ward. Although both the male and female quiet rooms remained in place and each contained a television, neither was operational at the time of our visit and there was a lack of seating. We discussed this with the SCN, including plans for improving the use of these spaces. We were advised that consideration was being given to how best to enhance these areas, including potential new furniture, to make them more welcoming and functional for individuals. We look forward to seeing these developments in future visits.

Overall, we were encouraged by the progress made in relation to the ward environment since our previous visit, particularly the closure of the contingency bed.

Individuals reported feeling safer in the ward environment and described an improved sense of space and calm, which supported a more therapeutic atmosphere. We would emphasise the positive impact this change had on individuals' experience of care and would encourage the service to maintain this improvement.

## Any other comments

Individuals, relatives and staff spoke positively about the care, treatment and support provided, and we found a caring, compassionate and therapeutic culture on the ward. We were encouraged to see improvements in individuals' participation in care and treatment, access to therapeutic activity, the ward environment, risk assessment, multidisciplinary working and the quality of daily clinical records. We also welcomed the closure of the contingency bed, which had improved individuals' privacy, dignity, and the therapeutic environment.

While the quality of care being delivered was generally of a good standard, we identified ongoing areas for improvement in care planning, multidisciplinary review arrangements, CI documentation and the application of Adult Support and Protection procedures to ensure that documentation, governance and practice consistently support individuals' rights and recovery.

## Summary of recommendations

**Recommendation 1:**
Managers should ensure that all care plans are fully completed, regularly reviewed and updated to reflect individuals' current needs. Care plan reviews should include a clear evaluation of progress, the effectiveness of interventions, any changes required to meet agreed goals and evidence of individuals' participation in care planning and decision-making.

**Recommendation 2:**
Managers must ensure that organisational arrangements in Hermitage Ward do not compromise individuals' rights to coordinated multidisciplinary assessment, review and care planning. All individuals must receive regular formal MDT review with appropriate multidisciplinary input and meaningful participation in decisions about their care and treatment.

**Recommendation 3:**
Managers must ensure that staff understand and implement their statutory responsibilities under the Adult Support and Protection Act and local procedures. Where there are concerns that an adult may be at risk of harm, referrals to the local authority must be made promptly and in accordance with statutory duties, regardless of the individual's legal status under mental health or incapacity legislation.

**Recommendation 4:**
Managers should ensure that continuous intervention (CI) care plans and associated documentation are fully aligned with the NHS Lothian continuous intervention standard operating procedure. Care plans should clearly record the rationale for CI, therapeutic aims, multidisciplinary interventions, planned review arrangements, criteria for reducing or ending CI and the individual's views. Managers should implement a regular audit process to provide assurance that CI documentation is completed consistently and accurately reflects the therapeutic care and review being provided.

## 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.

## Contact details

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