Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report

Mental Health Services Safe Delivery of Care Inspection

Royal Edinburgh Hospital

NHS Lothian

17 – 19 June 2025

Published November 2025

www.healthcareimprovementscotland.scot

About our inspection

Background

The current Healthcare Improvement Scotland Adult Mental Health inspection programme was developed as part of a range of actions to support and improve NHS adult mental health services in Scotland in the context of the COVID-19 pandemic and beyond. Although the initial focus of this work was on infection prevention and control, it was agreed with Scottish Government to broaden the inspection focus from infection prevention and control to a broader assurance function, creating a new and revised 'safe delivery of care' assurance model in NHS adult mental health units.

Our revised methodology will incorporate the HIS Quality Assurance System Quality Assurance Framework and will consider a wide range of standards such as the Health and Social Care Standards (2017) and the new Core Mental Health Quality Standards and indicators (2024).

Further information about the methodology for adult mental health inpatient services safe delivery of care inspections can be found on our website.

Our Focus

Our inspections consider the factors that contribute to the safe delivery of care. In order to achieve this, we:

- observe the delivery of care within the clinical areas in line with current standards and best practice
- attend hospital safety huddles
- engage with staff where possible, being mindful not to impact on the delivery of care
- engage with managers to understand current pressures and assess the compliance with the NHS board policies and procedures, best practice statements or national standards, and
- report on the standards achieved during our inspection and ensure the NHS board produces an action plan to address the areas for improvement identified.

About the hospital we inspected

Royal Edinburgh Hospital provides acute psychiatric, forensic and mental health services, including learning disabilities and dementia services. As well as mental health wards, Royal Edinburgh Hospital also has a number of learning disability wards, the Scottish Neurobehavioral Rehabilitation Service, the Ritson clinic for substance misuse and the Cullen Centre which is home to the Lothian eating disorder service and the art therapy service.

The wards visited in the Royal Edinburgh Hospital are part of the 'Royal Edinburgh and Associated Services (REAS) division of NHS Lothian. The services are provided for people from across Lothian and the wider region.

About this inspection

We carried out an unannounced inspection to Royal Edinburgh Hospital, NHS Lothian, on Tuesday 17 June to Thursday 19 June 2025 using our safe delivery of care inspection methodology. We inspected the following areas:

- Balcarres
- Braids
- Caanan
- Craiglockheart
- Cramond
- Divert suite
- Fairmile
- Harlaw
- Hawthorn
- Hermitage
- Margaret Duguid unit
- Meadows
- Merchiston
- Myreside
- Orchard

During our inspection, we:

- inspected the ward and hospital environment
- observed staff practice and interactions with patients, such as during patient mealtimes
- spoke with patients, visitors and ward staff, and
- accessed patients' health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Lothian to provide evidence of its policies and procedures relevant to this inspection. The purpose of this is to limit the time the inspection team is onsite, reduce the burden on ward staff and to inform the virtual discussion session.

Throughout July and August 2025, we held a number of discussion sessions with key members of NHS Lothian staff to discuss the evidence provided and the findings of the inspection.

The findings detailed within this report relate to our observations within the areas of the hospital we inspected at the time of this inspection.

We would like to thank NHS Lothian, and in particular all staff at Royal Edinburgh Hospital, for their assistance during our inspection.

A summary of our findings

Our summary findings from the inspection, areas of good practice and any recommendations and requirements identified are highlighted as follows. Detailed findings from the inspection are included in the section 'What we found during this inspection'.

We observed good multidisciplinary team working to provide person-centred care and treatment. We observed kind and respectful interactions between staff and patients throughout the hospital. Patients were able to access a range of therapeutic activities offered by the Hive, a charity service based within the hospital grounds. Senior managers also explained that a range of third sector partners support therapeutic activities on site. As well as The Hive, Cyrenians, Artlink and the Lothian Health Charity also provide activities across the site on a day-to-day basis and an active NHS Lothian Volunteering presence provide a programme of activities including supporting patient volunteering opportunities.

Additional training and initiatives such as the assistant practitioner programme for healthcare support workers were in place. There were sufficient numbers of suitably prepared staff to provide supervision and assessment of student nurses in the practice learning environment. Students nurses told inspectors they were keen to return to Royal Edinburgh Hospital.

Staff were open and transparent about the current challenges they face in relation to the use of non-standard care areas throughout the hospital.

During our onsite inspection we raised several concerns with senior managers relating to the care of patients within non-standard care areas. We raised concerns around risk assessments, unassessed ligature points, environmental challenges, and staffs' ability to carry out continuous observations. We also raised concerns relating to the fire risk assessments and the lack of appropriate fire doors.

Several requirements have been given in relation to a lack of effective systems in place to support the delivery of safe care within non-standard care areas. Whilst we acknowledge the immediate action taken by senior managers to address our concerns, we are not assured that effective systems were in place to support the delivery of safe care within non-standard care areas in Royal Edinburgh Hospital. We will return to

carry out a follow-up inspection, to assess and monitor improvement in response to these concerns.

Other areas identified for improvement include improving staff compliance with mandatory training in areas such as fire safety and life support training and improving communication with patients and families.

What action we expect the NHS board to take after our inspection

This inspection resulted in six areas of good practice, four recommendations and 21 requirements.

A requirement in the inspection report means the hospital or service has not met the required standards and the inspection team are concerned about the impact this has on patients using the hospital or service. We expect all requirements to be addressed, and the necessary improvements implemented.

A recommendation relates to best practice which Healthcare Improvement Scotland believe the NHS board should follow to improve standards of care.

We expect NHS Lothian to address the requirements. The NHS board must prioritise the requirements to meet national standards. An improvement action plan has been developed by the NHS board and is available on the Healthcare Improvement Scotland website: www.healthcareimprovementscotland.scot

Areas of good practice

The unannounced inspection to Royal Edinburgh Hospital resulted in six areas of good practice.

Domain 2	
1	Students reported positive practice and learning environments and support from staff within clinical areas and that they would be keen to return (see page 25).

Domain 4.3	
2	Staff received a debrief following any incidents and have psychology input into these sessions when required (see page 33).
3	Daily nursing staffing huddles appeared inclusive and structured, giving an overview in real-time, and provided staff with opportunity to escalate and discuss mitigation (see page 33).

Domain 6	
4	We observed caring, compassionate and person-centred care (see page 36).
5	Ongoing quality improvement work surrounding bed huddles and patient flow (see page 37).
6	Wards were proactive in gaining patient and carer feedback (see page 37).

Requirements

The unannounced inspection to Royal Edinburgh Hospital resulted in 21 requirements.

Domain 1	
1	NHS Lothian must ensure that all patient care documentation is accurately and consistently completed and reviewed (see page 21). This will support compliance with: Quality Assurance Framework Criteria 3.1 and relevant codes of practice of regulated healthcare professions.
2	NHS Lothian must ensure policies and procedures are in place for staff to follow to ensure consistent and safe delivery of care when working in an unfamiliar area (see page 21). This will support compliance with: Health and Social Care Standards (2017) Criteria 1.3, 1.20, 1.24, 3.14, 4.11, 4.14 and 5.19 and Quality Assurance Framework Criteria 2.2, 4.1 and 6.1.
3	NHS Lothian must ensure staff who are carrying out continuous interventions provide proactive, responsive and personalised care to support safe patient care (see page 21). This will support compliance with: Health and Social Care Standards (2017) Criteria 1.19, Quality Assurance Framework Criteria 1.5,2.1 and 2.2 and Core Mental Health Standards (2023) Criteria 2.3 and 4.11.
4	NHS Lothian must ensure potential risks to staff or patients are assessed to ensure the safe delivery of care. This includes, but is not limited to, ensuring that staff are aware of the policies and procedures in place for providing care in non-standard care areas (see page 21). This will support compliance with: Health and Social Care Standards (2017) Criteria 4.11, 5.1 and Quality Assurance Framework Criteria 4.1, 5.3 and 6.2.
5	NHS Lothian must ensure that all staff complete the necessary training to safely carry out their roles. This includes, but is not limited to, life support, adult support and protection, child support and protection and fire safety training (see page 21). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 Criteria 12II & Core Mental Health Standards (2023) Criteria 4.1 & 4.5 and relevant codes of practice of regulated healthcare professions.
6	NHS Lothian must ensure environmental ligature risks are assessed, and relevant staff are trained to recognise and manage ligature risks. The board must ensure effective training completion and oversight of ligature risk assessments and that any identified risks are robustly mitigated. This includes, but is not limited to, non-standard care areas (see page 21).

	This will support compliance with: Health and Social Care Standards (2017) Criteria 5.19 & 4.19 and Quality Assurance Framework Criteria 2.6.and 4.1.
7	NHS Lothian must ensure staff are supported to care for patients being cared for in wards that are not aligned with their specialty (see page 21). This will support compliance with: Health and Social Care Standards (2017) Criteria 1.20, 3.14 and 3.18.
8	NHS Lothian must take steps to understand and reduce the number of medication incidents (see page 21). This will support compliance with: Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society and Royal College of Nursing, January 2019) and relevant codes of practice of regulated health professionals.
9	NHS Lothian must ensure there are effective risk management systems and processes in place to ensure the safe delivery of care, including where additional beds or non-standard care areas are in use. This includes, but is not limited to, ensuring fire risk assessments are updated to reflect the use of non-standard care areas and fire doors are replaced when identified as not being compliant (see page 21). This will support compliance with: Fire Safety (Scotland) Regulations (2006), The Fire (Scotland) Act (2005) Part 3, NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017) and Health and Social Care Standards (2017) Criterion 5.19.

Domain 2	
10	NHS Lothian must ensure that senior managers and leadership oversight support is effective, to reduce the risks for staff and patients and support staff wellbeing (see page 25). This will support compliance with: Health and Social Care Standards (2017) Criteria 4.23 & Quality Assurance Framework (2022) Criteria 2.3, 2.6 and 5.5.
11	NHS Lothian must ensure processes and procedures are in place to support effective communication and feedback from incident reports (see page 25). This will support compliance with: Quality Assurance Framework (2022) Criteria 4.1 and A national framework for reviewing and learning from adverse events in NHS Scotland (2025).

Domain 4.1	
12	NHS Lothian must ensure staff comply with the locked-door policy and that the necessary ward specific signage and risk assessments are in place (see page 28). This will support compliance with: Health and Social Care Standards (2017) Criteria 2.7.
13	NHS Lothian must ensure that wards adhere to the audit schedule, and these are planned and organised in a way that provides assurance that high quality care is being delivered (see page 28). This will support compliance with: Health and Social Care Standards (2017) Criteria 4.11 and relevant codes of practice of regulated healthcare professions.
14	NHS Lothian must ensure that all used linen, clinical waste, including full sharps boxes, are stored in a safe locked area whilst awaiting uplift and are labelled as per guidelines (see page 28). This will support compliance with: National Infection Prevention and Control Manual (2023) Criteria 1.9.
15	NHS Lothian must ensure staff comply with the uniform policy (see page 28). This will support compliance with: NHS Scotland National Uniform Policy, Dress code and Laundering Policy 2018 and NHS Lothian Dress Code Policy 2023.

Domain 4.3	
16	NHS Lothian must ensure that there are appropriately trained staff in place to deliver high quality and safe care at all times. This includes medical, nursing and other allied healthcare professionals (see page 33). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
17	NHS Lothian must ensure there are clear, robust systems and processes in place to support the full and consistent application of the common staffing method (see pages 33). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
18	NHS Lothian must ensure that there are consistent systems and processes in place to support management of any identified staffing risks. This includes recordings of risks and mitigation/inability to mitigate when decisions around staffing are being made (see page 33).

	This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.

Domain 6	
19	NHS Lothian must ensure effective communication with patients and carers (see page 37). This will support compliance with: Health and Social Care Standards (2017) Criteria 2.11.
20	NHS Lothian must ensure that when patients are cared for in non-standard care areas, this is regularly risk assessed, and suitable mitigations are put in place to maintain patient dignity, respect and choice (see page 37). This will support compliance with: Health and Social Care Standards (2017) Criteria 4, 4.11.
21	NHS Lothian must ensure adequate staffing to enable meaningful activity to be provided to enhance recovery and promote wellbeing (see page 37). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 & Health and Social Care Standards (2017) Criteria 1.19 & 1.25 & Core Mental Health Standards Criteria 4.6.

Recommendations

The unannounced inspection to Royal Edinburgh Hospital resulted in four recommendations.

Domain 1	
1	NHS Lothian should monitor the impact on forensic areas regarding the implementation of the whole site violence and aggression training plan (see page 22).

Domain 2	
2	NHS Lothian should ensure ward staff have an opportunity to participate in staff meetings to support team discussion and information sharing (see page 25).

Domain 6	
3	Royal Edinburgh Hospital should explore ways to encourage patients to perform hand hygiene prior to mealtimes (see page 37).
4	NHS Lothian should consider creating a dedicated outdoor area for patients within rehabilitation wards to develop a therapeutic space (see page 37).

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

We observed multidisciplinary teams working to provide person-centred care and treatment. However, during the inspection we raised concerns with senior managers regarding the use of non-standard care areas as additional bedrooms throughout the hospital. Compliance with staff mandatory training was low in a number of areas including basic life support training, fire safety and adult support and protection.

Royal Edinburgh Hospital has 19 wards plus an additional divert suite in use that provides inpatient services for people with mental illness. This includes adult, older adult, intensive psychiatric care unit, rehabilitation and forensic wards. Referrals to Royal Edinburgh Hospital are generally made by community mental health teams, the intensive home treatment team and psychiatric liaison team based at Royal Infirmary of Edinburgh.

At the time of inspection, Royal Edinburgh Hospital was experiencing pressures such as reduced staff availability, delayed discharges and increased hospital capacity. In response to these pressures, in the week prior to our onsite inspection, NHS Lothian reopened a previously closed inpatient area to accommodate additional patients awaiting assessment and admission to the hospital, described as the 'divert suite'. Other non-standard care areas such as repurposed quiet rooms or interview rooms were also being used as additional patient bedrooms.

Prior to opening the divert suite, when no beds were available, patients that required inpatient admission would be cared for in the Emergency Department within the Royal Infirmary of Edinburgh on continuous intervention. We were told that the intention of the use of the divert suite was to prevent patients being cared for in the Emergency Department. Senior managers explained that the divert suite on the Royal Edinburgh Hospital campus is a dedicated clinical area that will be used temporarily to look after patients who have been accepted for admission via the unscheduled care pathway when there are no vacant beds either in NHS Lothian or in other NHS Boards in Scotland. During our inspection no patients who were required to be admitted to Royal Edinburgh Hospital were being cared for within the Emergency Department within the Royal Infirmary of Edinburgh.

NHS Lothian provided us with the standard operating procedure for when the divert suite is operational. The policy states that clinical information should be entered into the electronic care records and risk assessments, as would be required within an inpatient ward. For example, shift by shift entries, and use of mental health risk assessments to develop risk management strategies and care plans. It also explains that a patients' stay within the divert suite should not exceed 72 hours. Patients must be admitted to a hospital ward within this time or discharged home, should their condition improve. We did not observe any patients being cared for in this area for

longer than 72 hours during our inspection. The policy also describes that patients awaiting admission whilst being cared for in the divert suite should be nursed on a 1:1 basis, meaning each patient should have a dedicated nurse caring for them at all times. Additionally, a comprehensive risk assessment should be undertaken and an initial formulation and care plan agreed between the nurse and patient.

On the first day of inspection, three patients were admitted to the divert suite. Staff advised that when admitted to the divert suite patients are medically reviewed by the duty doctor and do not receive further senior medical review until admitted to the admission ward. The use of enhanced observations such as continuous intervention is the practice used to support patient safety and individual care to reduce the risk of harm to themselves or others. Healthcare Improvement Scotland's Scottish Patient Safety Programme 'From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care (2018)' guideline recommends a framework of proactive responsive and personalised care that focuses on prevention and early intervention in the context of a patient's deteriorating mental health. Inspectors observed that one patient was being cared for under continuous intervention with no care plan in place to support this. Inspectors observed limited interaction between the patient and staff members.

The divert suite was staffed with supplementary staff and staff from other areas of the hospital. The use of large numbers of supplementary staff who are not familiar with the care area or the patients' care needs can have an impact on the safe delivery of care. Nursing staff were unable to describe to inspectors why this patient required continuous intervention and also confirmed that no risk assessment had been completed to support the use of continuous intervention for the patient involved. This is not in line with NHS Lothian's standard operating procedure for the area, which explains that during admission to the divert suite a comprehensive assessment, including risk assessment, will be undertaken and an initial formulation and care plan agreed. Continuous intervention should be therapeutic in nature and should focus on supporting and working alongside the patient in their recovery and should be as least restrictive as possible. It should be specific, in line with the patient's needs, strengths, purpose of admission and evidence-based practice. We raised our concerns with senior managers immediately who ensured that the patients risk assessments and care plans were updated the following day. An additional staff member would also now be allocated to monitor patients requiring enhanced observations when being cared for within the non-standard care areas. A requirement has been given to support improvement in this area.

Senior managers provided assurance that during this period and as an interim measure, a senior charge nurse or charge nurse would be temporarily redeployed to provide more consistent leadership within the divert suite whilst recruitment for permanent staff was ongoing. We observed in evidence that recruitment was underway for permanent staff. Senior managers advised us that their recent recruitment for a senior charge nurse post for the divert suite was unsuccessful, however, additional interviews for band 7 senior charge nurses are scheduled for early

September. Whilst we recognise the steps NHS Lothian have taken to provide more stable leadership in the divert suite, a requirement has been given to support improvement in this area.

The decision to open the divert suite is authorised by Royal Edinburgh and Associated Services (REAS) service director or general manager. NHS Lothian's standard operating procedure describes that the patient's presentation will allow staff to risk assess if the divert suite is a suitable area for them to receive care. However, no formal risk assessment is described in the standard operating procedure. Lack of approved process to support staff decision making may result in an inconsistent approach which could lead to adverse outcomes for patients. We discussed this with staff working within the divert suite who described applying professional judgement to assess the suitability of the patients being cared for in these areas. However, inspectors observed no documentation or procedures in place to support and record professional judgement decisions. A requirement has been given to support improvement in this area.

NHS Lothian were using additional beds during our inspection in the majority of wards in acute services in Royal Edinburgh Hospital. This is a temporary hospital bed that is added to increase capacity during periods of high demand. At the time of inspection there were additional beds in use in the majority of adult acute admission mental health wards. These were in non-standard care areas such as repurposed interview rooms and quiet rooms. Inspectors also observed that seven previously closed beds were in use in one of the rehabilitation wards. Healthcare Improvement Scotland does not support the routine use of additional beds in non-standard care areas, as the standard of care provided in many of these areas falls below acceptable standards.

Inspectors observed that the majority of interview rooms and quiet rooms were being used as non-standard care areas. These rooms contained furniture including filing cabinets and desks which may have presented a ligature risk. A ligature risk is a potential for a patient to cause self-harm by using an object in conjunction with a fixed point or fixture. We raised this with senior managers immediately as a serious concern who responded by ensuring all furniture that posed a ligature risk within these areas was removed.

Several non-standard care areas had large windows facing into communal garden spaces with no curtain or blind available with some patients explaining that they were struggling to sleep as a result of this. One patient told inspectors about feeling unhappy at being cared for in one of these rooms, describing a lack of privacy and we observed that the patient had used a picture to cover the window as they had no blinds or curtains. We raised this as a serious concern at the time of the inspection. Patients being cared for in the non-standard care areas also did not have access to an ensuite toilet and shower facilities and instead required to use the communal facilities in the ward. The impact on patient privacy and dignity with the use of the additional beds is described further in Domain 6 of this report.

Inspectors observed that staff carrying out continuous interventions with patients being cared for in additional beds were not carrying out regular positive interactions or personalised care during these interventions. Instead, the majority of staff we observed were sitting outside the patients' rooms. Additionally, a few of these staff were also observed by inspectors to be focusing on their mobile phones at times. In some instances, inspectors observed that the bedroom door and blinds were closed making it difficult for the member of staff to observe or interact with the patient. As described earlier in this report inspectors had observed that there was additional furniture in these rooms that may have posed a ligature risk and that risk mitigations of these rooms included the use of continuous intervention of patients. We raised this with ward staff who also advised us that the magnets that operated these blinds were missing. We raised this immediately as a serious concern with senior managers who took action to ensure this was addressed immediately and confirmed that magnets were available in all ward areas to operate the internal blinds and that staff were carrying out continuous interventions correctly. A requirement has been given to support improvement in this area.

We asked NHS Lothian to provide details of incident reports submitted by staff in the three months prior to this inspection. In this we observed that there were several incidents where staff reported inappropriate patient placement due to potential ligature risk from the furniture or environment of the non-standard care area. We did not observe any incidents where staff reported patient harm due to inappropriate patient placement.

We raised concerns regarding these incidents with senior managers who were open and honest about the pressures for NHS Lothian in-patient mental health beds. Senior managers told us of plans to ease patient flow as new community flats, identified to be used for patients to be discharged into, would be in use by November 2025. They are hopeful that the use of these community flats will allow the closure of non-standard care area beds. They acknowledged that use of non-standard care areas as additional rooms were not designed to be bedrooms and that these were only planned to be used as a short-term response to increased demand for inpatient beds. Senior managers explained that they have attempted to mitigate the risks of the use of these rooms in a number of ways including the use of continuous intervention and ligature risk assessments. It was also explained that although there is no patient placement risk assessment for additional beds, there is a specific additional part of the mental health risk assessment around environmental ligature risk for inpatients who are admitted, which staff are expected to complete. However, our inspection has found instances where mitigation such as patient placement, risk assessment and continuous interventions were not being consistently applied. A requirement has been given to support improvement in this area.

During the course of our onsite inspection, we raised several concerns with senior managers relating to the care of patients within non-standard care areas. Whilst we acknowledge the response from NHS Lothian to address these concerns, we are not assured that effective systems are in place to support the delivery of safe care within

non-standard care areas in Royal Edinburgh Hospital. We will return to carry out a follow up inspection, to assess and monitor improvement in response to these concerns and requirements given.

NHS Lothian has a 12 bedded in-patient unit based in the Melville Unit, part of the Royal Hospital for Children which provides a regional service for young people within Lothian, Fife and Borders areas requiring in-patient psychiatric care. Service provision is for young people between 12 and 17 years inclusive. All under 18-year-olds should be admitted to specialist child and adolescent mental health beds wherever possible.

Senior managers explained that on occasions where a bed is not available for a Lothian, Fife or Borders patient, a bed is sought in either of the two other regional units for Children and Adolescent Mental Health Services in Scotland. Where there are no child and adolescent mental health beds available in Scotland, a bed may be required within Adult Acute Mental Health Services until a suitable bed is identified. Senior managers advised that if a patient under 18 years old was admitted to an adult acute mental health ward, they are provided with 1:1 care, 24 hours a day, by nursing staff from the child and adolescent unit. It was explained that this helps maintain the therapeutic relationship and allows the young person to have time out, do activities aligned to their age and provides a feeling of safety and security. The decision to admit a child into an adult ward would not be taken lightly and they would not be admitted to a non-standard care area. We did not observe any patients under the age of 18 years old being cared for in Royal Edinburgh Hospital during our onsite inspection.

We asked NHS Lothian to provide compliance rates for all the mandatory staff training programmes. In this we can see that compliance with management of violence and aggression training was over 70% in all areas. However, we observed low overall compliance rates for basic life support, fire safety and adult support and protection for Royal Edinburgh Hospital. In evidence provided we observed that basic life support training compliance was documented as 31% for staff based within the rehabilitation wards and 41% in the acute wards. Fire safety training compliance in the acute wards was recorded as 59%. Senior managers explained that they were currently moving from one learning platform to another which may have had an impact upon staff training records. However, we were not provided with any other evidence to reflect a higher training compliance rate. A requirement has been given to support improvement in this area.

Staff within forensic wards told inspectors that violence and aggression training was previously delivered in-house with dedicated trainers. However, now staff are undertaking the violence and aggression training that all NHS Lothian staff working in the Royal Edinburgh and Associated Services complete. Staff in the forensic wards explained to inspectors that they had concerns that this training wasn't suitable for the forensic environment. For example, the new training did not include specialised aspects that had previously been included such as the use of seclusion.

We raised these staff concerns to senior managers during feedback at the end of our onsite inspection, who explained the move to whole site training was to ensure parity

of training across all staff groups. In further narrative provided by senior managers, we were told that all training has been redesigned as scenario based to support de-escalation and decision making rather than teaching just the physical skills. However, all the techniques previously taught continue to be taught within the scenarios. From evidence provided the violence and aggression management group reported that the training had been delivered including the use of scenarios. Feedback from staff for this new method of delivering the training was positive, stating that they believed it was more realistic and focused on de-escalation rather than on restraining patients. Some staff reported to inspectors that they had no issues in relation to accessing the training and that they had recently received trauma training and spoke very highly of this. Whilst we have not observed any negative impact due to the change of training provided to staff in the forensic unit, a recommendation has been given to monitor the impact on forensic areas regarding the implementation of the whole site training plan.

Annual ligature risk assessments are part of an ongoing programme of assurance within NHS hospitals to reduce the number of incidences of self-harm or suicide by identifying potential ligature points and the controls and mitigations in place to reduce identified risks. NHS Lothian's ligature management project board has oversight of the ligature reduction programme.

In evidence provided we were given the Standard Operating Procedures for 'Environmental Ligature Point Inspections and Risk Assessments for all Clinical Areas within REAS'. In this we can see that ligature risk assessments should be reviewed annually and more frequently if any changes are made to the environment. We were provided with ligature risk assessments for the wards inspected however, we observed that different risk assessment templates were used throughout the hospital. We observed variance in the completion of these risk assessments, for example not all action plans had been updated. We also observed that some ligature risk assessment reviews were overdue, and some did not appear to reflect the use of the additional beds in non-standard care areas in acute adult wards. Senior managers explained to us that they had recognised that there had been inconsistencies in the completion of the ligature risk assessments throughout the hospital with a number of different templates in use. Senior managers also explained that a short-life working group had been commenced regarding ligature risk assessments. They were also aware that there was a limited number of staff who are trained to complete ligature risk assessments within the hospital with work ongoing to increase this. In evidence submitted to us, we were provided with minutes from the February 2025 Environmental Ligature Point Task and Finish Group which highlighted the need for further staff training in completion of the environmental risk assessment and that an electronic learning module was in development to provide staff training. In the minutes provided, we can see that an education subgroup is to be commenced to develop a training strategy for ligature risk assessment.

NHS Lothian provided us with evidence of this electronic learning module being procured. In this it is explained that the module will be made available to all staff

working within NHS Lothian's mental health units and acute 'front door' services. The aim of the module is to increase the completion and quality of the ligature point inspection and risk assessments, increase risk awareness and potential risks and ultimately reduce the number of patient safety incidents in relation to the use of ligatures. The training will be monitored and compliance reported to nurse directors across NHS Lothian. As this is in the early stages of development, we have not been provided with a date for the training to be commenced.

NHS Lothian provided evidence of ongoing works in the wards to improve the safety of fittings and fixtures. Staff told inspectors of an ongoing programme of work in relation to ligature reduction in patient bedrooms completed in the forensic unit, with the programme due to complete in August 2025. From evidence provided, there has been a business case submitted by NHS Lothian's short-life working group for ligature reduction work in patient bedrooms and en-suites across the whole site. However, the development of inpatient facilities for forensic, learning disability and rehabilitation has been stalled with the project unlikely to commence in the near future due to lack of available funding.

There are two entries on NHS Lothian's risk register in relation to ligature risk. One is due to the risk from ensuite bathroom and bedroom doors. Controls in place include individual risk assessment and environmental ligature risk assessment. This issue has been rated as 'high' and highlighted via health and safety reporting and clinical risk environmental group. During our discussion session, senior managers explained a current business case to procure new design and specification of bedroom doors that have electronic sensors and alarms to alert staff to pressure being placed on door edges from ligatures, as well as a new design and specification of ensuite doors that are considered safer than the existing door design. This was classed as high risk. The second entry was due to ligature risk from taps within ensuite bathrooms. Similar controls are in place to what are described for ensuite bathroom and bedroom door risks such as controlling access to ensuites depending on patient risk assessed level and ensuring patients are risk assessed regularly for self-harm or suicidality. Due to the findings of the inspection where we have observed inconsistencies with ligature risk assessments not being completed, a lack of oversight in the risk of ligature points in additional non-standard care areas and a low rate of training compliance for ligature risk assessment, a requirement has been given to support improvement in this area.

Inspectors observed that a patient who was under 65 years old was being cared for in the older adult ward and were told by nursing staff that this was a regular occurrence. Nursing staff explained that at times, this caused concern for staff when younger patients who were acutely unwell were being admitted to a ward with older adults. Patients with middle or late-stage dementia may require more assistance with comprehension, orientation and personal care. Those with functional illness may not understand unpredictable behaviours from others, and this may heighten anxiety and agitation. There is potential for increased workload and stress on staff as they must manage a wide range of patients with different behaviours, requiring different approaches for different patient groups. This is supported by findings in the Mental

Welfare Commission report on older people's functional mental health wards in hospitals (2020) which highlighted that mixing patients who are solely diagnosed with dementia with those who do not have that diagnosis is challenging and does not meet the needs of either group. Staff told us that at times they felt ill equipped to deal with these patients and in the evidence provided we can see that staff had completed electronic patient safety incidents in regard to this.

During our virtual discussion senior managers explained that patient placement includes a dynamic assessment and is based on professional judgement on where is safest for the patient at that time. However no formal documented risk assessments are recorded. A requirement has been given to support improvement.

Within incident forms we reviewed we observed the most commonly reported incidents related to violence and aggression and medication errors. We discussed this with senior managers who explained that nursing staff complete the medication competency framework upon commencing a nursing role in NHS Lothian. We were provided with a copy of this and can see that it signposts staff to relevant policies and procedures, with specific focus on areas such as safe controlled drug administration. During our discussion session, senior managers also explained that staff repeat this competency framework every two years. We were also told Royal Edinburgh and Associated Services have a pharmacy nurse that leads the incident review group. The group will look at new incidents, provide advice and guidance and suggest areas for further investigation if required. From evidence provided we observed that the medication competencies were discussed at the senior charge nurse meeting and that all staff have to complete these every two years. However, we did not receive compliance rates of these being completed or reviewed. A requirement has been given to support improvement in this area.

Up to date fire risk assessments were provided for all areas with the exception of the divert suite. However, a fire evacuation plan was provided. We had a virtual discussion with the Fire Safety Officer and contract manager on Wednesday 9 July 2025. They explained that the fire risk assessment had been updated following a change of use in June 2025 to the divert suite and was currently awaiting final approval from senior managers.

We were also told that fire risk assessments for a number of wards were also under review to reflect the use of additional beds in interview and quiet rooms. During this discussion we were told that some additional rooms in non-standard care areas do not currently have the correct standard of fire door and to rectify this it would require significant building work. It was explained that the use of continuous interventions was used as part of the mitigation of the risk of fire hazard within these areas. In evidence submitted by NHS Lothian, we can see that these concerns were raised at the Health and Safety Committee in April 2025. As described earlier in the report, fire safety training compliance rates throughout the hospital were identified as low during the inspection, and areas for improvement have been identified with the application of continuous interventions, with some patients not visible to the staff member due to

the door being closed or viewing panel in the door not functioning as a result of missing equipment to operate the internal blinds. Whilst senior managers were able to respond to these concerns immediately such as ensuring magnets to operate the blinds were available to staff and ensuring staff were undertaking continuous interventions, we are not assured of effective oversight of these mitigations being undertaken to ensure patient and staff safety. A requirement has been given to support improvement in this area.

Requirements

Domain 1	
1	NHS Lothian must ensure that all patient care documentation is accurately and consistently completed and reviewed.
2	NHS Lothian must ensure policies and procedures are in place for staff to follow to ensure consistent and safe delivery of care when working in an unfamiliar area.
3	NHS Lothian must ensure staff who are carrying out continuous interventions provide proactive responsive and personalised care to support safe patient care.
4	NHS Lothian must ensure potential risks to staff or patients are assessed to ensure the safe delivery of care. This includes, but is not limited to, ensuring that staff are aware of the policies and procedures in place for providing care in non-standard care areas.
5	NHS Lothian must ensure that all staff complete the necessary training to safely carry out their roles. This includes, but is not limited to, life support, adult support and protection, child support and protection and fire safety training.
6	NHS Lothian must ensure environmental ligature risks are assessed, and relevant staff are trained to recognise and manage ligature risks. The board must ensure effective training completion and oversight of ligature risk assessments and that any identified risks are robustly mitigated. This includes, but is not limited to, non-standard care areas.
7	NHS Lothian must ensure staff are supported to care for patients being cared for in wards that are not aligned with their specialty.
8	NHS Lothian must take steps to understand and reduce the number of medication incidents.
9	NHS Lothian must ensure there are effective risk management systems and processes in place to ensure the safe delivery of care, including where additional beds or non-standard care areas are in use. This includes, but is not limited to, ensuring fire risk assessments are updated to reflect the use of non-standard care areas and fire doors are replaced when identified as not being compliant.

Recommendation

Domain 1	
1	NHS Lothian should monitor the impact on forensic areas regarding the implementation of the whole site violence and aggression training plan.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

During the inspection we found staff to be open and transparent about what was working well and the current challenges they face. Some staff described concerns in the ongoing use of additional beds and the impact this had on staff throughout the hospital.

At the time of inspection the areas visited were calm and well organised with good leadership. Inspectors observed that in some wards charge nurses were present and approachable, communicating with staff regularly when any advice or support was needed. The majority of staff inspectors spoke with also described good leadership with opportunities for learning and developing as a team.

In the majority of areas there was clear communication between staff, with inspectors observing teams updating staff who did not normally work in the clinical area. Information was shared with staff through email, added to the safety brief or at team meetings. However, we were advised by staff that team meetings were not happening in every ward. A recommendation has been given to support improvement in this area.

Inspectors observed that ward communication includes a handover and a safety brief at the start of each shift. These were comprehensive, clear and person- centred. There is a 1pm hospital huddle which the housing officer also attends to ensure effective liaison with ward staff in relation to discharge planning. There were whiteboards with alerts and current clinical information in staff areas and inspectors were told that information was also shared through emails and during staff meetings.

Staff in the majority of wards spoke of good support from the clinical nurse manager and the chief nurse and from clinical educators around staff development. This included a programme of induction for new staff in older adult services that has resulted in a reported 100% retention rate over 3 years for newly qualified staff. However, staff in one ward told inspectors that they felt there is a lack of leadership at ward level and very limited input from managers above senior charge nurse level. The ward had recently had a change in leadership with a new senior charge nurse temporarily managing the ward. Staff in the ward described feeling isolated with low morale and that they were concerned that continuous interventions are not always facilitated due to a lack of available staff. Inspectors did not observe a lack of available staff to undertake continuous intervention in any of the wards we inspected. A requirement has been given to support improvement in this area.

In evidence provided, we observed one electronic report where staff had reported that continuous interventions in one ward were stopped overnight due to reduced staffing levels, meaning that the previous mitigations put in place due to risk could not be continued. There was no patient or staff harm identified on the electronic incident report. We raised this with senior managers at the virtual discussion who advised staff

are to escalate staffing concerns when this situation arises. In narrative provided by senior managers, we were advised that there had been no agreement to stop continuous intervention due to staffing on this occasion and that there are processes in place to ensure safe patient care such as the daily staffing huddles where senior managers will have oversight of staffing challenges and the movement of resources.

However, during the inspection, we identified a lack of alignment between the accounts provided by ward staff and the understanding of events described by senior managers. This suggests a potential disconnect in communication and shared understanding of operational decisions and their impact on care delivery. A requirement has been given to support improvement in this area.

Some ward staff we spoke with told us they felt that the majority of agency staff who covered shifts in the hospital were not familiar with these areas and this could be unhelpful. They also highlighted that staff communication skills were not of the level they would expect and this was frustrating for both patients and staff. Discussions with clinical nurse managers at Royal Edinburgh Hospital reported that any issues in relation to agency staff was raised with the staff bank as they will escalate concerns with relevant agencies. From evidence provided, there is a bank and agency staff induction which includes training required to be completed both online and in person. New bank and agency staff are allocated a supervisor to complete the induction within three months of commencement in post.

Senior managers hold a weekly gold and silver command meeting to discuss current pressures experienced within Royal Edinburgh Hospital. Gold command takes place on a Thursday morning with Silver command on a Tuesday for follow up actions. Strategic objectives for gold and silver command are to protect the safety of patients, staff and the public, reduce delays and unmet needs in the system and maximise bed capacity and ensure effective flow management. We had the opportunity to attend these meetings and found them well attended by senior managers, the medical director, senior nursing staff and senior allied health professionals. We observed these were well structured meetings with action plans and time scales being placed on objectives.

In wards inspected we observed good multidisciplinary working. Input in some wards included occupational therapy, pharmacy, psychology and social work and also support from tissue viability, where required. In one ward, Edinburgh City Council social work also worked with the multidisciplinary team. However, staff within one ward told us that patients only had input from psychology or social work if this had been instigated prior to the patient being transferred into the ward from elsewhere in the hospital. In some wards inspectors were told that there were significant gaps in the provision of psychological services. Psychology input helps provide a holistic understanding of a patient's thinking and behaviours and work to identify triggers and how staff can work with patients displaying distressing behaviour. The National Institute for Health and Care Excellence explains that psychological intervention should be part of routine treatment within inpatient mental health wards. Vacancies

within psychological services in Royal Edinburgh Hospital are discussed further in Domain 4.3.

The Nursing and Midwifery Council (NMC) Standards for Student Supervision and Assessment outlines the roles and responsibilities of practice supervisors and assessors, ensuring that student nurses receive mentorship through high-quality support, and supervision during their practice placements. In evidence provided, we can see there were sufficient numbers of suitably prepared staff to provide supervision and assessment of student nurses in the practice learning environment. Within senior management meeting minutes and feedback to inspectors with students on placement, we can see that students who had completed placement were keen to return to Royal Edinburgh Hospital.

Areas of good practice

Domain 2	
1	Students reported positive practice and learning environments and support from staff within clinical areas and that they would be keen to return.

Requirements

Domain 2	
10	NHS Lothian must ensure that senior managers and leadership oversight support is effective, to reduce the risks for staff and patients and support staff wellbeing.
11	NHS Lothian must ensure processes and procedures are in place to support effective communication and feedback from incident reports.

Recommendation

Domain 2	
2	NHS Lothian should ensure ward staff have an opportunity to participate in staff meetings to support team discussion and information sharing.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

There was no allocated enclosed outdoor space in the older wards such as rehabilitation or longer-term wards. Patients who wished to go outdoors had to be accompanied by a staff member. Staff reported being unable to complete therapeutic one-to-one conversations with patients due to staff pressures and the reduced availability of private spaces. This was as a result of interview rooms and quiet rooms throughout the hospital being repurposed to create additional beds.

The majority of the documentation we reviewed was complete and up to date however, inspectors observed some patient risk assessments were not completed in some wards. We observed good documentation of multi-disciplinary team meetings within the notes.

Staff told us about the new system of electronic notes that had recently been introduced, which included a new mental health care plan. Staff reported to inspectors that confidence in using this was variable, however a clinical educator was in the wards to support and train staff. In the rehabilitation wards, the care plans inspectors reviewed were comprehensive and up to date with clear goals and objectives. Integrated Care Pathways were produced with patient involvement and updated following a three-monthly review meeting.

Staff shared with us their challenges in transferring information to a new person-centred care planning system which had recently been introduced. The new care plans were developed in conjunction with the Mental Welfare Commission and quality improvement team who had delivered care plan workshops for all areas within Royal Edinburgh Hospital. In wards who were fully using the new care plan we observed good completion of these.

Within the wards inspected, the patients cared for included those detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. We observed that the main ward doors are locked for the safety and security of patients. Wards were accessible with a swipe card apart from the forensic unit, divert suite and wards in the old building which was key access. We spoke with senior managers at the time of the inspection who explained that all staff working in these areas had keys. Within some of the wards inspected, inspectors observed that there was no signage to guide patients and visitors leaving the ward, although staff were available to guide patients and visitors. As part of the requested evidence, we were provided with NHS Lothian's locked door policy which states that wards should have signage in relation to how to exit the ward. A requirement has been given to support improvement in this area.

A regular programme of audit can support early identification of risks, support compliance with policy, and maintain patient and staff safety. NHS Lothian provided us with audits for risk assessment, care plans, nursing notes and continuous intervention for the previous three months prior to inspection. We observed poor compliance with

the completion of the majority of audits, and within one clinical area this was as low as 20.1%. In evidence provided, we observed low compliance rates in both healthcare acquired infection audits and mental health audit tools. Audits on patients' progress notes were the only section which was meeting over 90% compliance. Senior managers told us that a new care assurance standards nursing post has been created to support the audit process and work with wards and staff to increase compliance. A requirement has been given to support improvement in this area.

Standard infection control precautions should be used by all staff at all times to minimise the risk of cross infection. These include patient placement, hand hygiene, the use of personal protective equipment (such as aprons and gloves), management of patient care equipment and the care environment, safe management of blood and fluid spillages, linen and waste management, and prevention and exposure management (such as sharps injuries).

Personal protective equipment such as gloves and aprons were accessible, and staff observed this to be stored correctly. Inspectors observed that the ward had sufficient stocks of personal protective equipment.

Hand hygiene involves ‘5 moments’ when hand hygiene should be performed. These are prior to touching a patient, prior to performing a procedure, after procedure or body fluid exposure risk, after touching a patient or after touching a patient’s surroundings. Practicing good hand hygiene helps reduce the risk of the spread of infection. We observed alcohol-based hand rub was not available in patient areas due to patient safety reasons and staff did not carry personal alcohol-based hand rub. An alcohol-based hand rub was available for staff in locked areas. We had limited opportunities to observe staff carrying out hand hygiene as personal care was delivered in patients’ rooms.

Other standard infection control precautions such as linen, waste and sharps management minimise the risk of cross infection and must be consistently practiced by all staff.

In most areas clinical waste and linen appeared to be managed and stored in line with national guidance. Inspectors observed that not all sharps boxes were labelled with information. This is not in line with the National Infection Prevention and Control manual which stipulates that sharps boxes must be labelled with date of assembly, point of origin and date of closure.

In one ward inspectors observed dirty laundry and clinical and general waste stored in the same room as patients’ belongings. Inspectors observed the floor was visibly contaminated with fluid leaking from the general bin store. This was raised with senior managers who reported that they would take action to rectify this at the time. A requirement has been given to support improvement in these areas.

The environment in the wards was variable. The new wards were clean and appeared well maintained. The other wards based in the old building had recently undergone redecoration and were bright and appeared clean. The patient equipment we

observed was clean and well maintained. However, the environment was bare, with limited decoration on the walls to personalise it. One ward had dormitory rooms with two patients per dormitory. These were large rooms with curtains used to provide privacy.

There was no allocated enclosed outdoor space in the older wards such as rehabilitation or longer-term wards and patients who wanted to go outdoors had to be accompanied by a staff member, if required following assessment of risk.

Inspectors observed variable compliance with NHS Lothian's uniform policy. Inspectors found staff mainly wore NHS Scotland or agency uniform, making it easy to identify different staff groups. However, some agency staff were seen wearing a combination of uniform and their own clothes. This could make it difficult for patients to identify staff groups. A requirement has been given to support improvement in this area.

Inspectors were advised by staff in one ward that a water outlet had returned a positive legionella result during routine testing. From evidence provided, this was discussed regularly at Infection Prevention and Control meetings with updates on a number of negative tests and a timeline for reopening the area. The affected water outlet had been closed off for patient use. At the time of the inspection two clear tests had been confirmed, and following the third clear test we were told the area will be reopened.

Requirements

Domain 4.1	
12	NHS Lothian must ensure staff comply with the locked-door policy and that the necessary ward specific signage and risk assessments are in place.
13	NHS Lothian must ensure that wards adhere to the audit schedule, and these are planned and organised in a way that provides assurance that high quality care is being delivered.
14	NHS Lothian must ensure that all used linen, clinical waste, including full sharps boxes, are stored in a safe locked area whilst awaiting uplift and are labelled as per guidelines.
15	NHS Lothian must ensure staff comply with the uniform policy.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

Whilst we observed staff to be working hard to provide safe and effective care, we observed nurse staffing levels are consistently reported as being below established staffing levels in a number of the wards inspected. We observed a high use of supplementary staff throughout the site. However, NHS Lothian were able to evidence significant work being undertaken to improve staffing levels throughout the hospital.

NHS Lothian submitted workforce data that demonstrated that band 5 nursing vacancy rates were 16.2% in rehabilitation, 9.4% in adult services and 8.5% within older adults. We can also see that vacancy rates in adult mental health services within the senior charge nurse roles were 22.8% and charge nurse roles at 11.9%. We consider a vacancy rate above 10% to be high.

Senior managers explained that the vacancies in the senior charge nurse and charge nurse roles were currently being addressed with recruitment underway. During our discussions, we were also told that recent recruitment from the cohort of newly qualified nurses will mean that almost all band 5 vacancies will be filled. Senior managers also explained that they had created pathways to develop staff, in particular healthcare support workers. There has been an introduction of band 4 assistant practitioner roles and successful applicants would commence a 12-month training programme with Edinburgh College. Upon completion, trainees will be educated to Scottish Credit and Qualification Framework Level 8 and will be able to demonstrate competencies for any specific skills required to undertake the role. During our discussion session senior managers explained the introduction of the assistant practitioner roles provides a career pathway for unregistered nursing staff which it is hoped would encourage staff to progress to undertake their graduate nurse training.

NHS Lothian use supplementary staffing such as staff bank or agency to help cover staffing shortfalls left by absence, vacancy and increased service demand. Supplementary staffing includes substantive staff working additional hours, staff from the NHS board's staff bank or staff from an external agency. During our onsite visit, inspectors observed a high number of agency and supplementary staff working in the clinical areas inspected, for example to provide continuous interventions for patients being cared for in non-standard care areas rooms. In some areas, nursing staff raised concerns with inspectors that agency staff appeared to not have the skills or training required to safely fulfil their role. We raised this with senior managers at the time of our inspection who explained that all staff must have all mandatory training completed prior to being able to access shifts in the hospital.

Evidence in electronic incident reports provided to us as part of the inspection highlighted a number of incidents where registered agency nursing staff have been described as not being appropriately trained to deliver expected care or having made an error. This includes not assisting in restraint and medication errors. Senior

managers explained to us the process that they would follow if they had any concerns regarding a staff member's ability and how this would be fed back to the staff bank or agency.

During our onsite inspection, forensic wards were observed to not use agency staff due to the specialised nature of the environment, however nursing staff explained to inspectors that they did occasionally use bank staff who were familiar with the area.

Nursing staff within older adult wards told inspectors that they had never had to escalate any staffing issues beyond clinical nurse manager level. They felt they were well supported with opportunities to develop their skill base.

It was observed by inspectors that a high rate of agency use was due to the increased levels of continuous intervention in relation to the use of additional beds. This was raised with senior managers who explained that there was a business case for increasing establishment which was provided in evidence. In this we can see that it has been recommended to increase the use of whole-time equivalent nursing staff by 124.83. This includes an increase in night duty staffing of 39.46 whole time equivalent staff.

We observed significant vacancy gaps in medical establishment in psychology services across all mental health services. Those gaps appear to be present on a long-term basis (existed when reviewing data from May 2024). Significant gaps were noted particularly in band 8a roles with establishment variance reaching above 40% and in consultant level establishment variance being 57% for submitted data in May 2025. We have asked the senior team about any impact of those gaps on staff wellbeing and quality and safety and on management and mitigations of those gaps.

We met with the acting director for psychology on Monday 11 August 2025, who reported that the clinical director post for psychology has been vacant for two years and that it has been difficult to recruit more senior psychological posts. We were told that this has led to a gap in staffing resulting in a number of clinical areas not having dedicated psychological support. It was also explained that psychology do not attend the Royal Edinburgh and Associated Services daily staffing huddle however they would escalate any staffing concerns to the acting director of psychology.

During our meeting it was explained that a review of psychology services is due to commence and it is anticipated staffing concerns would be identified within this review. The importance of patients accessing psychological therapies alongside medical treatments has been described earlier in the report. A requirement has been given to support improvement in this area.

We were able to discuss well-being initiatives with the well-being lead for Royal Edinburgh Hospital. There is a permanent 'work well facilitator' that works across the Royal Edinburgh and Associated Services. This service is able to be responsive to staff needs and work with teams to help access micro funding grants for staff wellbeing. There is a well-being space within Royal Edinburgh Hospital which is open 24/7 with the area also being bookable for team sessions. The facilitator is able to signpost staff

to corporate services and is responsible for staff engagement and wellbeing programme which includes wellbeing communication and monthly round up emails. From evidence received the monthly emails include upcoming events and links to online resources for mental wellbeing.

Staff spoke of being well supported following any incidents and NHS Lothian provided their Adverse Event Management Policy which details staff support following an incident. Staff told us there were debriefs from incidents and also informal debriefs. One ward reported that they had psychology input following a particularly challenging patient and staff informed inspectors that these debriefs are often led by the consultant psychiatrist.

In relation to Duty 12IH: adequate time for clinical leaders, time to lead is a legislative requirement under the Health Care Staffing (Scotland) Act (2019). This is to enable clinical leaders to provide and oversee the delivery of safe, high quality and person-centred healthcare.

As described earlier in the domain, evidence provided highlights leadership gaps, high staffing absence and concerns reported by staff in relation to the quality of care being delivered, which would suggest that protected time is being compromised. Frequent use of supplementary staffing as well as a high number of less experienced staff who require support and supervision would highlight the need for additional clinical leadership and oversight. We have asked senior managers how they support clinical leaders with the time to lead duty. NHS Lothian recognised that protecting leadership time can be a challenge however, stated that they have a process in place to support their clinical role and supervisory role. Where protected time is being compromised, this is being recorded within the real time staffing assessment tool. We have had an opportunity to speak to senior charge nurses who provided positive feedback on their leadership time provision, although stating this experience may vary as other mental health services are facing different demands and clinical pressures.

The Health and Care (Staffing) (Scotland) Act 2019 commenced on 1 April 2024. It stipulates that NHS boards have a duty to apply the Common Staffing Method which includes a staffing level tool run and requires this to be applied rigorously and consistently. The application of the common staffing method and staffing level tools supports NHS boards to ensure appropriate staffing, the health, wellbeing and safety of patients and the provision of safe and high-quality care.

NHS Lothian shared information on roles and responsibilities, explaining the annual tool run process, including reporting process and template and describing establishment review ‘health check’ methodology. NHS Lothian describes the health check as a process that allows staffing levels to be understood, opportunities and challenges to be identified, and solutions to be found. It is a methodology developed within NHS Lothian to facilitate review of staffing levels.

NHS Lothian demonstrated using data from the real time staffing tool and data related to their nursing workforce establishment. We discussed with senior managers the

process for common staffing method application and consideration of quality and safety elements including recurrent risks. We were informed that discussion including these considerations takes place on ward level with senior charge nurses. However, senior managers confirmed that locally developed reports would demonstrate that the application of the common staffing method has not yet been completed for all services.

We observed that the establishment review included outcomes from staffing level tool runs, however evidence suggests that there has been only one roster area that has utilised the required staffing level tool in the period between April 2024 until March 2025. The Health and Care (Staffing) (Scotland) Act (2019) requires boards to apply the common staffing method and staffing level robustly and sets the minimum frequence for use of staffing levels tool at least once per year. In further narrative provided by NHS Lothian, we were told that the delay was due to new mental health calculators being implanted in October 2025 prior to running the staffing tool run again. A requirement has been given to support improvement in this area.

We were told by staff on one ward that they did not complete incident reports for unsafe staff levels as they had no time to do this. In evidence provided, other clinical areas had submitted online reports in relation to low staffing. During our discussion session senior managers explained that they would not expect staff to complete an electronic patient safety incident in regard to staffing levels unless this has been identified as a contributing factor to a safety incident. Instead, any staffing data should be captured on the electronic staffing system which is reviewed and updated daily.

As part of this inspection, we were able to attend the 1pm staffing huddle within mental health inpatient services of Royal Edinburgh Hospital. We were able to observe this process in practice with NHS Lothian utilising the electronic staffing system. This acts as a visual tool, which considers the acuity of the patients versus available staffing numbers and allows for professional judgement to be made in terms of required staffing. We observed open and transparent huddles providing a real time overview of the staffing levels including acuity and dependency and discussion of possible mitigations such as redeployment of staff to ensure adequate safe staffing cover. However, we observed some inconsistencies in recording staffing risks when utilising the electronic tool and have not observed recordings of discussed mitigations or recordings of those being acted upon. In our discussion with senior managers, they acknowledged this gap in recording, however confirmed staff are being supported in use of the tool and written formal guidelines are in place. The observations of the site huddles demonstrated that there was input from mental health nursing services and the overall processes appeared robust. Senior managers appeared to be responsive to risks and concerns raised by staff during the safety huddle we attended. However, in terms of multi-professional staffing consideration, the process did not seem so clear. We have asked senior managers if they had a system in place that would allow consistent assessment of, and capture of, real-time staffing risk across all clinical professional groups. We were told that there are meetings in place to communicate any staffing gaps within the psychology service, occupational therapy and medical

team and communication on ward level as part of multidisciplinary working. A requirement has been given to support improvement in this area.

As described earlier in the report, during our discussion with the acting director of psychology we were told that they do not attend the hospital safety huddle and instead escalate any potential staffing risks internally.

Areas of good practice

Domain 4.3	
2	Staff received a debrief following any incidents and have psychology input into these sessions when required.
3	Daily nursing staffing huddles appeared inclusive and structured, giving an overview in real-time, and provided staff with opportunity to escalate and discuss mitigation.

Requirements

Domain 4.3	
16	NHS Lothian must ensure that there are appropriately trained staff in place to deliver high quality and safe care at all times. This includes medical, nursing and other allied healthcare professionals.
17	NHS Lothian must ensure there are clear, robust systems and processes in place to support the full and consistent application of the common staffing method.
18	NHS Lothian must ensure that there are consistent systems and processes in place to support management of any identified staffing risks. This includes recordings of risks and mitigation/inability to mitigate when decisions around staffing is being made.

Domain 6 – Dignity and respect

Quality 6.1 – Dignity and respect

We observed warm and respectful interactions between patients and staff and person-centred interaction based on best practice models for dealing with distressed behaviour. The use of mixed sex wards creates challenges for staff and patients with an impact on privacy. We also observed that the use of quiet rooms and interview rooms reduced the opportunity for patients to access meaningful activities.

During the inspection, we observed staff treating patients with care and compassion, showing dignity and respect and communicating clearly and sensitively.

We observed that staff and patient interactions were positive, and patients were treated with dignity and respect. Staff appeared to know their patients well. Patients were given a choice from a menu, dietary needs and their preferences and were encouraged to make their own tea/coffee/cold drinks promoting independence,

where possible. Mealtimes were observed to be well organised and the patients who required support received it quickly and thoughtfully, however we did not observe patients being supported with hand hygiene prior to meals. A recommendation has been given to support improvement in this area.

As described earlier in the report, the divert suite had been opened in the week prior to our inspection. Inspectors spoke with a patient awaiting admission to one ward and their family. Both the family and the patient told inspectors they were happy that their relative was in a safe place. The family then explained to inspectors that they were offered no information on the process of admission or what to expect in relation to the care provided. They felt unsure if their relative would be admitted and were worried that an admission would not happen and that their relative would be at risk. This was raised with staff at the time of inspection who advised they would speak with the family. However, relatives raised with inspectors again that they still had not been provided with this information at the end of our onsite inspection. A requirement has been given to support improvement in this area.

Mixed sex accommodation can impact patient dignity and personal choice. Most of the wards in Royal Edinburgh Hospital are single sex accommodation however, there are five mixed sex wards. Two wards inspected were mixed sex wards though both wards cared for patients in single room accommodation. One ward had a locked door where male and female corridors joined however, they could still mix in the communal area. Staff in both wards stated it worked well and did not highlight any issues. In evidence provided there were completed risk assessments for all mixed sex wards. The risk assessments highlighted potential hazards such as risk of inappropriate behaviour, breach of privacy and possible safeguarding concerns, and persons at risk with appropriate mitigating factors should concerns arise such as an increase in staff to patient ratio. In evidence submitted by NHS Lothian, we did not observe any incident reports in relation to the use of mixed sex wards.

Delayed discharge refers to situations where a patient who is clinically ready to leave hospital, cannot do so because the necessary care, support, or accommodation is not available. This can occur for various reasons, such as waiting for care home placement, community care arrangements, or adaptations to a home environment. At the time of inspection, there were 28 patients experiencing delayed discharge in the clinical areas inspected. Any delay in discharge can have a detrimental effect on a person's health and wellbeing, including the loss of independence and confidence. Senior managers also explained that six patients who were being cared for in Royal Edinburgh Hospital were awaiting transfer to another hospital out with NHS Lothian and closer to their home.

At the time of inspection, Royal Edinburgh Hospital had two delayed discharge coordinators that had been in place for five weeks. The focus of the discharge coordinators is to provide a link between the wards and services that would provide care and support to a person awaiting discharge and these are discussed at the daily bed huddle. Quality improvement work is being undertaken to ensure daily bed

huddles are as efficient as possible with the necessary staff attending and data provided. Inspectors were able to attend daily bed huddles during the inspection and observed that these were well attended by nursing staff, with staff knowledgeable about patients who were experiencing delayed discharge and individual person-centred reasons for delay.

Outdoor spaces in mental health wards play a crucial role in patient well-being, recovery, and overall therapeutic care. Wards had some outdoor space, the majority of which consisted of small courtyards with seating and some flowers. In one ward they had large courtyards with flowerbeds, and they had recently received funding to refurbish their football pitch. However, as described earlier in the report, patients being cared for in the rehabilitation ward had no access to outdoor space unless given passes or taken out on outings with staff. A recommendation has been given to support improvement in this area.

Smoking has been banned in public places in Scotland since 2006 by virtue of the Smoking, Health and Social Care (Scotland) Act 2005. However, the law still exempts residential mental health services. Inspectors observed that there were fixed ward wide times to go out of the wards to smoke if a nurse escort was required which was not patient-centered. The wards offered nicotine replacement therapy as an option for people.

Staff explained to inspectors that as interview rooms and quiet rooms were being used as non-standard care areas for additional beds in many of the wards, it left few spaces for private medical discussions, psychology sessions or spaces to see visitors. During our inspection, inspectors did not observe any medical discussions being held out with private rooms. However, we did observe that this restricted the space available for therapeutic activities or quiet space available for patients away from the main areas of the ward. This was the only room in some wards where patients could watch sports on television with one patient explaining to inspectors that they enjoyed watching football and this had led to them being unable to access this. A requirement has been given to support improvement in this area.

The provision of meaningful activity on mental health wards is said to increase social connectedness, improve psychological wellbeing and is essential to promote wellbeing and recovery. In the majority of wards inspected there was a timetable of activities and in one ward inspectors observed patients had access to football tournaments, competitions, gardening groups and yearly barbecues. In some wards inspectors were told staff took patients on outings. All wards had a recreational nurse, with one ward just recently recruiting one. Patients also had access to the ‘Hive’, which is an activity centre run by the hospital charity that offers varied activities for those staying in hospital, within the grounds of the hospital. We had the opportunity to observe coffee mornings taking place in some wards during the inspection. One ward runs a cooking programme where patients are supported to buy and cook their own meals on a 1:1 basis. Another ward has cooking sessions run by the occupational therapist. All wards

have patient laundries where patients are supported/encouraged to do their own laundry.

Forensic services had very good provision of allied health professionals including occupational therapy and art and music therapy. There was a nurse therapist delivering Cognitive Behavioural Therapy and Dialectical Behaviour Therapy and three forensic psychologists which can enhance a patient's treatment and outcomes. Speech therapy and physiotherapy were a service every ward could access through referral. Staff also told us of the use of 'what matters to me' to enhance patient involvement in care. Ward staff within the older adult wards explained to inspectors that they had worked closely with Macmillan nurses to provide palliative care and had previously had support from diabetes service which provided staff with specialised clinical advice to improve patient care.

However, in other areas inspected we identified variability in the availability of allied health professional input. Some wards had full time occupational therapists and activity coordinators and some currently had none. As described earlier in the report, nursing staff in some wards told us of a gap in accessing psychology input.

On one ward we spoke with the activity nurse who told us there was a timetable of activities that he made while being aware of the Hive. This was a full-time post however, we were told of occasions where there are staffing shortages, the activity nurse would be required to support the wider nursing team with general nursing duties. On another ward we were told the activity coordinator was also required to support wider nursing duties, therefore not able to carry out the role of activity coordinator. A requirement has been given to support this area.

Royal Edinburgh Hospital utilises varied structured and informal methods to gather and act on patient feedback. The Patient Experience Team is the central point for receiving patient feedback for NHS Lothian. On a day-to-day basis the patient experience team manage all complaints, concerns, compliments, and stories shared on Care Opinion, as well as support the implementation of new ways of gathering patient experience.

Inspectors observed that some wards obtain patient feedback through patient meetings and other wards offer a weekly two-hour open session for patients. Inspectors were advised by ward staff that this meeting is well attended, and patients are seen on a one-to-one basis by a senior charge nurse or charge nurse. There is also a carers group once a month and patient council meetings, which are structured forums involving patients, carers and staff to discuss experiences, feedback and improvements. From evidence provided there was a letter sent to carers and patients representatives inviting them to patient council meetings to encourage attendance.

Areas of good practice

Domain 6	
4	We observed caring, compassionate and person-centred care.

5	Ongoing quality improvement work surrounding bed huddles and patient flow.
6	Wards were proactive in gaining patient and carer feedback.

Requirements

Domain 6	
19	NHS Lothian must ensure effective communication with patients and carers.
20	NHS Lothian must ensure when patients are cared for in non-standard care areas, this is regularly risk assessed, and suitable mitigations are put in place to maintain patient dignity, respect and choice.
21	NHS Lothian must ensure adequate staffing to enable meaningful activity to be provided to enhance recovery and promote wellbeing.

Recommendations

Domain 6	
3	Royal Edinburgh Hospital should explore ways to encourage patients to perform hand hygiene prior to mealtimes.
4	NHS Lothian should consider creating a dedicated outdoor area for patients within rehabilitation wards to develop a therapeutic space.

Appendix 1 - List of national guidance

The following national standards, guidance and best practice were current at the time of publication. This list is not exhaustive.

- Allied Health Professions (AHP) Standards (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, September 2024)
- Core Mental Health Quality Standard (Scottish Government, September 2023)
- Delivering Together for a Stronger Nursing and Midwifery Workforce (Scottish Government, February 2025)
- Fire Scotland Act (Acts of the Scottish Parliament, 2005)
- Food, fluid and nutritional care standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland, November 2014)
- From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care (Healthcare Improvement Scotland, January 2019)
- Generic Medical Record Keeping Standards (Royal College of Physicians, November 2009)
- Health and Care (Staffing) (Scotland) Act (Acts of the Scottish Parliament, 2019)
- Health and Social Care Standards (Scottish Government, June 2017)
- Infection prevention and control standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland, May 2022)
- Mental Health (Care and Treatment) (Scotland) Act (Acts of the Scottish Parliament, 2003)
- National Infection Prevention and Control Manual (NHS National Services Scotland, January 2024)
- Healthcare Improvement Scotland and Scottish Government: operating framework (Healthcare Improvement Scotland, November 2022)
- Prevention and Management of Pressure Ulcers - Standards (Healthcare Improvement Scotland, October 2020)
- Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society and Royal College of Nursing, January 2019)
- Rights, risks, and freedom to limits (Mental Welfare Commission, March 2021)
- Staff governance COVID-19 guidance for staff and managers (NHS Scotland, August 2023)
- Standards for student supervision and assessment (Nursing & Midwifery Council, April 2023)

- The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, October 2018)
- The quality assurance system and framework – Healthcare Improvement Scotland (Healthcare Improvement Scotland, September 2022)

Published October 2025

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999
or email contactpublicinvolvement.his@nhs.scot

Healthcare Improvement Scotland

Edinburgh Office
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

0131 623 4300

Glasgow Office
Delta House
50 West Nile Street
Glasgow
G1 2NP

0141 225 6999

www.healthcareimprovementscotland.scot