Mental Welfare Commission for Scotland

Report on unannounced visit to:
Stratheden Hospital, Lomond Ward, Springfield, Cupar, KY15 5RR

Date of visit: 14 May 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

Lomond Ward is a 29-bedded, mixed-sex, adult acute admission ward that provides care and treatment for individuals who reside in the Fife area. On the day of our visit, there were 26 people on the ward.

We last visited this service in June 2025 on an announced visit and made 10 recommendations. The recommendations included improvement around person-centred care planning processes and ensuring individuals had access to provision of therapeutic activities, occupational therapy (OT) and psychology services. We made recommendations on 'do not attempt resuscitation' (DNACPR) certificates, and the authorisation of treatment for individuals subject to Mental Health (Care and Treatment) (Scotland) Act, 2003 (Mental Health Act) legislation. Recommendation were made on the prescribing and administration of intramuscular medication for informal people, individual's funds being managed under Part 4 of the Adults with Incapacity Act (AWI Act), the locked door policy and compliance with smoking legislation.

The response we received from the service was outlined in a detailed action plan.

On the day of this visit, we wanted to follow up on the previous recommendations and look at how the service had actioned these. We were keen to hear from individuals about their experience when admitted to the ward.

Who we met with

On the day of the visit, we met with eight individuals and reviewed the care notes of six of these people.

As the visit was unannounced, we wanted to give people the opportunity to speak with us over the following week, should they wish to do so. We therefore requested the SCN to inform relatives of the visit to allow anyone to contact the Commission following the visit if they wanted to speak with us.

We spoke with a further three individuals who were receiving care and treatment and received feedback from one relative.

We spoke with the senior charge nurse (SCN), the charge nurse (CN), the lead nurse, a consultant psychiatrist and ward staff. We also met with senior leaders from NHS Fife at our feedback session.

We also contacted advocacy services following on from the visit.

Commission visitors

Tracey Ferguson, social work officer
Susan Tait, nursing officer
Dr Juliet Brock, medical officer

What people told us and what we found

We spoke with people who had recently been admitted to the ward and others where they had been in for a longer period. We also met with some people who told us that they had been in another acute ward before being transferred to Lomond Ward.

We received mixed feedback from the people we spoke with; some provided positive feedback and others were less positive in their views.

Everyone we spoke with told us that there was “nothing to do” on the ward. Most people told us that they laid in their bed most of the day as there was no therapeutic engagement or activities. We found this to be the case on the day of the visit, which was similar to last year’s visit.

One person told us that it was up to themselves to get better. A few people told us that they were unable to maintain skills - such as making meals and doing their washing - while on the ward. The ward did not have the facilities to maintain these particular activities and learn new ones. We heard from several people that although there were clothes washing facilities, access to this area was difficult due to the facilities being located in a staff corridor and staff were needed to gain access. We also heard similar feedback about accessing the activity room, as this room was also based in the same location.

We heard from several people about the uncertainty regarding their discharge from hospital and there were a few people who told us that they did not feel involved in their care and treatment.

People told us that they generally felt safe on the ward, however, this depended on who was admitted to the ward. Individuals told us that there was often a lack of privacy due to the shared dormitories and it was difficult to find a quiet space due to the lack of privacy in this area, as well as a lack of quiet spaces and rooms in the ward. This was similar to what we were told during our the last visit.

Some individuals told us that they were not happy with being in hospital, nor were they happy with their treatment. Those people told us that they had to rely on medication to get better as there was no other forms of treatment.

For those who were not happy at being in hospital, we wanted to ensure that people knew their rights. However, what we heard did not reassure us that people had been informed of their rights and we spoke to advocacy and the SCN about this. We were aware that when some individuals were admitted to the ward, this may have resulted in them having a lot of information to process and it is important that individuals are regularly advised of their rights and how to exercise these throughout their journey.

All individuals we spoke with told us that they met regularly with the consultant psychiatrist and that this had provided them with the opportunity to discuss their

treatment and express their concerns and objections. For some people, we heard that they felt more involved in their recovery journey than others that we heard from.

Some people said to us that often, they felt they were not listened to and this led to them feeling as if they were not involved in decisions around their care and treatment.

We heard feedback about the staff on the ward. A few individuals that we spoke with told us that “the staff were ok”. We also heard “some better than others”, “staff were compassionate” and “lovely”. We asked individuals about one-to-one sessions with staff and were told that these rarely took place. Most of those that we spoke with recognised that staff were always busy.

We asked people about their care plans and if they had been involved or had seen these. All individuals we spoke with told us that they had not seen their care plans, nor been involved in their development, which we found disappointing.

People again raised smoking as an issue. This was due to people being permitted to continue to smoke in the garden area, despite legislation in place to prohibit this.

We were aware from our last visit that the ward had a number of vacant band 5 registered nursing posts. The SCN nurse told us that there had been an ongoing recruitment drive to fill these posts and that the ward now had a little over three full time vacancies to fill, which was an improvement from last year.

We heard that the ward had been given an increase in their staffing levels following work that the service had done with Healthcare Improvement Scotland about safe staffing levels. The ward had recruited a significant number of newly qualified staff into the vacant posts, who required additional time from the existing staff and the leadership team in order to support, mentor and supervision from the new staff members.

The SCN told us that depending on clinical demand, they often had to be counted into the numbers on a shift, and that due to vacancies the ward still required to use bank or agency staff. From speaking to staff, we heard that the team were supportive and that there were ongoing learning opportunities, but at times due to how busy the ward could be, this was difficult.

Ward based nursing staff told us that there were occasions where some staff have had to be moved out of Lomond Ward due to clinical demands in another area; this meant the staffing levels in Lomond Ward would often go into ‘amber’, directly impacting on staff being able to deliver some aspects of care, such as one-to-one discussions and activities. We are aware that the health board are undertaking work with Healthcare Improvement Scotland to ensure safe staffing levels and that all wards are required to meet the obligations of the Health and Care (Staffing)

(Scotland) Act, 2019.The lead nurse and SCN told us that in order to ensure safe staffing levels were in place, there was a staff huddle each morning between senior staff; this was to ensure wards had sufficient staffing to meet the clinical needs and demands in each area.

On the visit in 2024 we made a recommendation for the managers to consider the current bed capacity in the ward. The lead nurse told us that although the ward still had capacity for 29 people, they had capped the number of bed usage to 22, plus two 'surge' beds. On this visit we heard how the number of people being admitted had exceeded these levels due to clinical demand and pressure on beds.

Care records

Care records were held on the electronic system, MORSE. We found this easy to navigate and were able to access the relevant documents.

Documents were stored under specific sections and we were told that it could be difficult to find where they had been stored, as it would depend on where the staff member who started the document had saved it to. While on another local visit to a service in Fife, senior managers had informed us that this was being looked at, and we will continue to request updates during our local visits.

Care, treatment, support, and participation

Most of the care and treatment on Lomond ward continued to be provided by the nursing team as this ward did not have dedicated input from ward-based allied health professionals (AHPs), such as OT, psychology and physiotherapy.

We wanted to find out about how the service was implementing our recommendations from our previous visit with regards to OT and psychology provision. We had been told on last year that a clinical psychology formulation test of change had previously been undertaken and written up as an SBAR (situation, background, assessment and recommendation) report for the senior leadership team. The SBAR recommended that there should be provision for clinical psychologist input as part of the multidisciplinary team (MDT).

We are aware from the action plan we received that a decision was still to be made in relation to this; we will write to the Chief Officer with regards to an update on this and as this recommendation has not been met, we will repeat this recommendation.

Recommendation 1:
Managers must ensure that there is psychology provision available to the individuals in the ward.

We wanted to find out how the service had implemented our recommendation about OT provision. From the submitted action plan from the service, it noted that the managers responsible for AHP recruitment and service delivery were working to

address the recruitment challenges, and to increase the availability of OT services to the ward.

Senior managers told us that there were several OT vacancies across the service and unfortunately, they had not managed to recruit to the vacant posts.

Recommendation 2:
Managers should ensure that the ward has dedicated input from OT.

Again, we heard from the service that the absence of regular OT was as issue, as they provided a valuable service for individuals who required functional assessments, recreational and therapeutic interventions.

This was also similar to input from psychology, where the service told us that not having dedicated psychology sessions often left the nursing staff having to manage complex clinical issues. At the time of the visit, we were provided with some examples where individuals who were currently in the ward would have benefitted from psychology input.

In the daily continuation notes we would expect to see evidence of an individual's progress, contact with their keyworker or engagement in ward-based therapeutic/recreational activities.

Since our last visit, the ward had introduced a new electronic proforma, to enable recordings to be captured in a way that provided a holistic update regarding individuals presentation on that day. We found some proformas that were detailed, although this was inconsistent across the records we viewed. We provided examples of the completion of those records at our feedback meeting and shared that it was important to address this through staff supervision and audit processes to improve consistency. It was positive to hear about the change made to format of the daily recording form and we will continue to review progress during future visits.

Part of this new proforma allowed staff to evidence one-to-one meetings with individuals; we found that one-to-one meetings were not happening regularly.

We saw entries in the care records such as "no engagement, spent time at bedspace" or "fresh air breaks". It was difficult to know if the person had been asked and had refused a one-to-one with the staff member due to the lack of detail in the recording. We heard back from individuals that these were not happening and were not being offered. We advised that one-to-one meetings could provide an opportunity for staff to discuss the care plans and the review of these, as well as discussions about individuals' rights.

The SCN told us that the ward had just introduced a new system and on a daily basis, there will be agreement as to which nurse will be responsible for doing one-to-one

sessions with individuals. We look forward to seeing improvement in this area on our next visit.

Care planning

We wanted to find out how the ward had implemented our last recommendation about care plans. We found on last years' visit that there was a variable standard in care plans, and that plans we reviewed were not person-centred; we were concerned to find that not everyone had care plans in place, and where people did, they lacked evidence of participation and involvement of the individual.

Following the last visit, the action plan submitted by the service set out how they planned to meet this recommendation. We were told that a short life working group with Fife Health and Social Care Partnership (HSCP) had been convened to review the care plan process and the associated template, to improve person-centred care.

We were advised that the ward nursing team would use the HSCP documentation audit tool to monitor compliance with governance and assurance processes, to ensure standards were achieved and maintained in respect of care planning.

We heard that the ward leadership team promoted individual involvement and person-centred care by drawing on the Commission's published good practice guide on care plans[1] which is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

We found care plans that were detailed and person-centred. There were regular reviews in place, but these were not completed consistently. Some would have benefitted from a better description about the interventions that were required. We found one individual who had been admitted to the ward for over a month had no care plans in place and another person who only had one care plan in place under the heading "discharge".

This was similar our previous visit, where we found not everyone had a care plan in place. We found some care plans recorded interventions such as 'to build a therapeutic relationship' and 'offer one-to-one sessions' but we found that regular one-to-one meetings did not appear to be taking place; this was confirmed by the individuals we spoke with.

We found that there had been no consistent improvement and it was unclear throughout a person's admission if and when care plans were discussed with them.

The SCN told us that new laptops and iPads had been purchased so this would enable staff to take the electronic record to the individual when devising their care

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

plan. At last year's visit we had heard that the service was in the early stages of developing an audit tool that was appropriate to their service area although we were told that there had not been any change to this tool.

The action plan that we received had not met this recommendation therefore we will repeat the same recommendation as we made last year.

Recommendation 3:
Managers should ensure that everyone admitted to the ward has a detailed, person-centred care plan which evidences individual and carer involvement and participation and is reviewed regularly. There should be a regular audit process in place to monitor and improve the quality of the care plans.

We wanted to follow up on the recommendation about DNACPR certificates. At the time of this visit, we were told that there was no one in the ward that required this to be in place. We received information back from the service as to how they would meet this recommendation and were advised that an audit process was in place and could evidence compliance with the completion of DNACPR certificates in accordance with the national policy. We will continue to review progress on future visits across the service.

All of the care records we reviewed had a risk assessment in place and these were mostly detailed although risk management plans varied in the level of detail that was provided.

We also found that some of the reviews lacked detail; it was unclear if the risk was being managed, or if the intervention that had been put in place to manage the risks was effective.

Recommendation 4:
Managers should ensure that all risk management plans provide a detailed account of how each risk will be managed along with evidence of ongoing review of the risks.

Multidisciplinary team (MDT)
MDT meetings took place four times per week and consisted of the consultant psychiatrist and nursing staff. There was one consultant psychiatrist who covered the ward. We were told that individuals and their named person or relative could also attend this meeting where appropriate.

We heard there was also regular attendance at those meetings from community staff, including community psychiatric nurses and mental health officers (MHOs), when necessary.

The record of the MDT meeting was completed on the electronic system, MORSE. We were aware from our last visit that there had been changes to the MDT meeting format and saw this on other recent visits to different services across NHS Fife.

We found the meeting records to be detailed, where they clearly identified attendees and captured their views. The record of the meeting summarised the individuals' weekly progress and provided a good account of the person's ongoing mental and physical health care.

Similar to last year, as the MDT only consisted of the consultant psychiatrist and nursing staff. From reviewing peoples care records we were able to see the complex presentations that those that were being admitted with and gained a sense that there was a reliance on nursing care and psychotropic medication. There were no psychological formulations or other psychological treatment approaches in place.

Many individuals in the ward had a noted history and experience of trauma, where they presented with an additional diagnosis, such as emotional unstable personality disorder. They had no input from the wide range of professionals that would have been helpful in aiding their recovery and discharge.

We were told that there were seven people who were ready for discharge from hospital but that their discharge had been delayed. We were told that the reasons for delays related to accommodation, care packages and legal processes. We heard that the discharge coordinator continued to request updates from the ward and community staff.

Use of mental health and incapacity legislation

On the day of the visit, 21 people were detained under the Mental Health Act and all documentation relating to individual detention status under Mental Health Act was in place and held in each individual electronic record.

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. We wanted to follow up on our previous recommendation to see how the service was implementing this. We were told that there were weekly audits completed by nursing staff and where any issues arose, there was a clear escalation process in place.

We found several issues with the treatment certificates (T2 and T3) that had been completed to authorise treatment under the Mental Health Act. We found that the treatment certificates did not always correlate with the medication being prescribed. We will follow this up with the consultant psychiatrist, SCN and senior managers in the service.

We wanted to follow up on our previous recommendation around the prescribing of 'if required' intramuscular (IM) psychotropic medication. The Commission has concerns about IM 'as required' psychotropic medication being included on T2 certificates, as any advance consent the individual has given is invalid if they have withdrawn their consent at a later time when the medication is given or if restraint is involved. It is our view that where IM medication has been prescribed 'as required' in hospital, it should be authorised on a T3 certificate. We were pleased to find that no one had been prescribed or administered IM psychotropic medication and that there was an audit process in place to pick up on this issue.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act (the AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

We found that staff were not clear who had section 47 treatment certificates in place. Following discussion with the consultant psychiatrist, we had concerns that there may have been people who required one due to lack of capacity but we were told as they were 'consenting', a certificate was not required. If an individual is unable to give informed consent due to a lack of capacity, then a s47 must be completed to authorise treatment.

Recommendation 5:
Managers must ensure that where a person has been assessed as lacking capacity for treatment in relation to physical treatment that there is an AWI Act section 47 certificate in place along with an accompanying treatment plan, as per the code of practice for medical practitioners.

There was a white board displayed on the wall in the staff clinical area which recorded individual details; we were told that this was to provide a quick overview for staff. On last year's visit we suggested to the SCN that it would be beneficial for the white board to display information regarding AWI Act status, but we found that this information had not been added to the board.

Where a person had an appointed proxy decision maker in place under the AWI Act, we found it difficult to locate the documentation and again it was not clear from the white board who was subject to which part of the specific legislation. We found that not all paperwork was held electronically and some paper records did not contain the legal paperwork.

Recommendation 6:
Managers must ensure that all Mental Health Act and AWI Act documentation is stored consistently for all individuals and that all staff are aware of the legal framework that everyone is subject to, which should be clearly recorded on the white board.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where an individual had nominated a named person, we found a copy in the file. We were aware that some individuals admitted to the ward may not be able to nominate a named person at the stage of admission. We advised that this should be discussed with them throughout their admission and that individuals were supported to revisit their decisions with input from the staff, an MHO or advocacy.

We wanted to follow up on last year recommendation about the money that people had access to and that was being managed by the hospital managers under the AWI Act. We were told that a regular audit would be in place to measure compliance with policy. This information was not easy to locate and accessible.

We could not locate the incapax certificate in the care records therefor we repeat this recommendation.

Recommendation 7:
Managers must ensure that when a person's monies are being managed under part 4 the AWI Act there is a system in place to ensure this is clearly recorded in the individual care records and the certificate of incapax is kept in their care record.

Rights and restrictions

On the day of our visit, there were no individuals in the ward who required to be on continuous intervention.

The door to the ward was locked and there was a locked door notice at the entrance to the ward, with the locked door policy displayed on a wall in the ward. We were aware from other visits that the locked door policy was being reviewed, and we will seek an update from senior managers about this.

We had some feedback about access to the ward and about the time it can often take for a staff member to answer the door. Individuals, a relative and advocacy told us that staff can be seen in the office but do not come to the door. People felt they were being ignored. The SCN told us that the answering of the door and letting people out of the ward for time out, was the role of the floor nurse.

Individual's time off the ward was recorded as part of ward policy. We discussed this further with the SCN and felt that it would be appropriate to display this on the notice and inform individual's and relatives on admission.

The ward had good support from the local advocacy organisation, Voiceability and we were pleased to find that this service was available for everyone and not just for people who were detained under the Mental Health Act. Some of the individuals we spoke with had a good understanding of their rights, whereas others appeared to be unsure. We are aware that advocacy attended the ward weekly and people had the opportunity to discuss and meet with them.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital. Where an individual is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. We wanted to find out how the service had implemented specified person procedures, which we raised prior to last year's visit and where4 the service had put in a separate action plan to address this.

We were informed that three people were subject to specified person legislation.

We found paperwork in place, except for one person and we asked for this to be reviewed. The Commission has produced good practice guidance on specified persons[2]. The ward had implemented specified person care plans which were being reviewed regularly however, there was lack of review at the MDT meeting.

When we are reviewing individual files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We found one copy on file.

We wanted to find out more about how the health board was promoting these for individuals admitted to this ward as we did not find any care plan or documentation that identified discussions had taken place with individuals. While we recognise that individuals may be not be able to make one at the time of admission, we did not find if there were further discussions or follow up, either in one-to-one meetings or during care plans reviews or on discharge. This would also be an area where advocacy could support individuals, if appropriate, to make an advance statement.

The ward had a patients' rights pathway displayed on the wall before they entered into the ward, which was informative and provided guidance. We suggested to the SCN that it would be beneficial for nurses to support people in developing care plans around people's rights, particularly for informal people. We saw that an individual's time out of the ward was being restricted but were unsure if the person had agreed to this restriction as this was not recorded in the care record.

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

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 would expect to see person-centred activity programmes which are based on a multidisciplinary assessment of everyone's needs and strengths. Such a programme should include options for activities both on and off the ward, where appropriate, for therapeutic and recreational activity and reflect peoples social, cultural and religious preferences.

We wanted to follow up from our visit last year and find out about the investment that the NHS Fife had made in activity provision, to support people's recovery on Lomond Ward. The ward did not have a dedicated activity therapist in place and there was no provision in place from AHPs to provide this.

We were told that there had been ongoing discussions with the AHP manager about the repurposing of posts across the health board in order to contribute and deliver therapeutic activity provision across the service, which was positive to hear.

We were informed on this visit that approval was now in place to progress with creating posts, and these posts had already gone out for advert. We will continue to request an update from senior managers and look forward to seeing the implementation of activity provision across all the wards.

Some people told us they had accessed the off-ward activity room but due to the location of this room, could only do with a staff escort.

The physical environment

The layout of the ward consists of six single bedrooms and four dormitory style rooms. Each of the dormitories had a shower and toilet area.

We found that some of the seals in the bathrooms were black and clearly in need of an upgrade, which was similar to what we found on last year's visit. We were disappointed to be told that no improvement work had been done.

There was a communal sitting area that had a few sofas and a television. There was a separate dining room off the corridor to the ward where meals were served. The sitting room had been repainted since our last visit and some chairs purchased.

Individuals told us about the lack of privacy on the ward, particularly with having to share dormitory rooms and bathrooms with others. People told us about the lack of

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

quiet rooms and space in the ward, especially if they needed to get away from the noise.

Individuals told us of their frustration that the laundry and activity rooms were in an area that they could not access independently. One person told us that on admission there were no doors on the toilet and the curtain that was in place did not cover the window. We found on the visit that people's privacy was infringed due to the lack of screening on the windows of the single rooms.

Although this ward has had some ligature reduction work carried out, this had not been completed throughout the ward. Since our last visit we were told that all the curtains in the dormitories have now been changed as part of the ongoing ligature reduction programme.

The SCN told us that there was a monthly care assurance walk around to check the environment and list what works needed to be done. The room where clinical records were stored had no covering on the windows and given this is an area that people could see directly into, we asked how this was going to be addressed. We were told that there were plans to put protective film across part of this window for privacy and confidentiality purposes.

Recommendation 8:
Managers must ensure that work is undertaken to the environment to meet people's needs in relation to their privacy, dignity and wellbeing.

The ward had access to a secure garden and access to extensive grounds across the hospital estate. On the day of the visit, we were disappointed to see the garden was being used by people for smoking. We also heard from people that they chose not to access the garden area due to people smoking there.

We asked the SCN about this, given that it is against the law to smoke or allow smoking within 15 metres of a hospital building in Scotland and also that we had made a previous recommendation around this. We were told that it had been difficult to implement this legislation, however staff were continuing to remind people of the no smoking policy. We were concerned that there appeared to be a lack of clear strategy around this and we will therefore repeat this recommendation.

Recommendation 9:
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

We are aware that there are ongoing plans to upgrade part of the Fife estate and that the Health board had been awarded £12 million from the Scottish Government over the next three years as part of refurbishment and upgrade works. We will therefore request an update from senior managers about the improvement works planned for Lomond Ward.

Summary of recommendations

Recommendation 1:
Managers must ensure that there is psychology provision available to the individuals in the ward.

Recommendation 2:
Managers should ensure that the ward has dedicated input from OT.

Recommendation 3:
Managers should ensure that everyone admitted to the ward has a detailed, person-centred care plan which evidences individual and carer involvement and participation and is reviewed regularly. There should be a regular audit process in place to monitor and improve the quality of the care plans.

Recommendation 4:
Managers should ensure that all risk management plans provide a detailed account of how each risk will be managed along with evidence of ongoing review of the risks.

Recommendation 5:
Managers must ensure that where a person has been assessed as lacking capacity for treatment in relation to physical treatment that there is an AWI Act section 47 certificate in place along with an accompanying treatment plan, as per the code of practice for medical practitioners.

Recommendation 6:
Managers must ensure that all Mental Health Act and AWI Act documentation is stored consistently for all individuals and that all staff are aware of the legal framework that everyone is subject to, which should be clearly recorded on the white board.

Recommendation 7:
Managers must ensure that when a person's monies are being managed under part 4 the AWI Act there is a system in place to ensure this is clearly recorded in the individual care records and the certificate of incapax is kept in their care record.

Recommendation 8:
Managers must ensure that work is undertaken to the environment to meet people's needs in relation to their privacy, dignity and wellbeing.

Recommendation 9:
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Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

When we visit:

- We find out whether an individual's care, treatment, and support are in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia, and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice, and guidance to people we meet with.

Where we visit a group of people in a hospital, care home, or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports, and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line, and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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