Mental Welfare Commission for Scotland

Report on announced visit to:
Royal Edinburgh Hospital, Craiglockhart Ward, Morningside Place, Edinburgh, EH10 5HF

Date of visit: 24 February 2025

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

Where we visited

Craiglockhart Ward is a 16-bedded, female, adult acute psychiatric admission ward with a catchment area that includes the northwest and east areas of NHS Lothian.

On the day of our visit, there were 18 people admitted to the ward. There was also one person who was boarding in another ward overnight and returning to Craiglockhart Ward during the day, totalling 19 people receiving care and treatment in Craiglockhart Ward. Two of the beds being used in the ward were contingency beds, with one bed that was placed in a room previously used as an interview/quiet room and the other bed was in what was previously the dedicated activity room. There was no storage, toilet or handwashing facilities in either of these two rooms.

We last visited this service as an unannounced visit in February 2024 and made seven recommendations which included the need to improve the quality and review of the nursing care plans, to consider developing the multi-professional team to include regular access to occupational therapy, to ensure individuals were supported to have meaningful participation in care planning and decisions about their care and treatment and that this participation be recorded within their clinical record. There was also a need to ensure that rights-based care was delivered to individuals and that information on rights was easily available and visible throughout the ward. We highlighted the need for specified persons legislation paperwork, including a reasoned opinion to be in place to authorise restrictions. We also recommended that consideration was given to providing a dedicated space in the ward for activities and lastly that the bed management and boarding arrangements were reviewed to ensure the individual's safety, welfare and well-being were prioritised.

On this visit, we were keen to follow up on these recommendations, hear about any progress and to meet with individuals, carers/relatives, and staff to hear their views and experiences on how care and treatment was being provided on the ward.

We were particularly interested to find out whether some of the designated areas that had been repurposed into makeshift bedrooms had been returned to their original purpose. We were disappointed to see that they had not and that there had been no progress made in four of the seven actions from 2024, including supporting and recording individuals' participation in their care and treatment, the provision, recording and promotion of rights-based care, the provision of a dedicated space for activities and the continued use of unsuitable rooms as bedrooms.

Who we met with

We met and spoke with eight people. We reviewed the care notes of six people, including some of whom we met with. We also met with a relative.

We met with the senior charge nurse (SCN), deputy nurse director (DND), consultant psychiatrists, charge nurses, psychologist, student nurses, other nursing staff and a trainee art therapist.

Commission visitors

Sandra Rae, social work officer

Anne Buchanan, nursing officer

What people told us and what we found

The individuals we met on the day of the visit gave various views and opinions about their care and treatment in Craiglockhart Ward.

We were informed that for one person they felt "safe" but they informed us that "the ward was often busy or noisy." They felt the nursing staff were "responsive and approachable" if they had any worries or concerns, they wished to discuss. We heard from others in the ward that staff were "too busy to provide the level of care and treatment" they thought they needed.

Other views we heard included comments such as "staff are run off their feet and have no time to spend building a therapeutic relationship with anyone", "staff left me in my room when I was first admitted and told me to come to the main area when I was ready, however I was frightened and came to hospital to heal, this was not a positive experience for me." One person told us they felt they had not been supported at all by staff or given any therapeutic input. They were about to be discharged, and they felt "let down and guilty", as they had left family to come to hospital to get well and felt there was no therapeutic help on the ward. They did feel the admission allowed them to work independently on their own issues, which they felt they could have undertaken in the community with the right input from community services.

An individual who had been sleeping in one of the makeshift bedrooms felt a lack of dignity, by not having any toileting or showering facilities like others in the ward.

Individuals spoke of there being "nothing to do on the ward and that the only activities that they knew about were put in place on the day of the Commission's visit". This significantly affected one person who was outraged by this. We heard from others that there were art therapy sessions in the ward that happened twice weekly in either group or one-to-one sessions, which was supportive for some people.

Many individuals commented that the ward would benefit from having the dedicated activity room back in use, as this was a therapeutic space that supported engagement in meaningful activity. We agreed with this point and raised this in our meeting with the management team at the end of the visit. This was recognised as important by those who attended the meeting.

We were informed that there was no activity co-ordinator in post as the position was vacant. However, to fill the void in the short-term, health care support workers were supporting this role. We found evidence of this and an activity timetable during our visit. We heard that the art therapy sessions were supportive for some people, but they only happened twice a week and not everyone on the ward could attend due to a

lack of space in the communal area, which was also used as a lounge and dining room.

We were told by some people they felt “unsafe” in the ward and others told us they preferred to remain in their bedroom as the ward environment could be “loud and stressful” at times. Some individuals told us that they tended to spend time in their bedroom to avoid the communal area, which they found “intimidating.” We heard that there was a lack of quiet space in the ward for individuals to use out with their bedroom.

One person told us that in their opinion, restraints happened regularly on the ward and lasted for longer than necessary.

Most individuals we spoke with reported that they had regular contact with their consultant psychiatrist, which some found positive. We heard that for the majority of people, they were not invited to attend their multidisciplinary team (MDT) meeting, which led to feelings about a lack of participation and involvement in their care and treatment.

We heard that for some individuals, they felt their pathway into hospital was poor. They informed us that they first had to be admitted to an emergency department in a hospital equipped to deal with physical health. They then had to wait for a psychiatric bed in the Royal Edinburgh Hospital and were nursed on a one-to-one basis for the duration of their wait. They felt this was a negative approach to mental health and left them feeling marginalised and a risk to others.

We were told by individuals that they felt unhappy and guilty that they were taking up a bed that others with physical ill health needed. We were also told of poor experiences of some people who were given a bed in the ‘surge ward’ before moving to Craiglockhart Ward. The surge ward had been put in place as a temporary measure to unlock bed capacity and deal with the competing demands for mental health beds across the hospital site but closed at the end of March 2025.

Most of the individuals we met with were unaware of their care plan, adding that they had not been involved in its completion. One individual raised their concern about the lack of discharge planning that had affected them; they felt more anxiety than they should, as they did not know if they were to have any community psychiatric nursing support on discharge.

We spoke with relatives who did not view the experience of their family member being admitted to the ward as positive. Relatives informed us they had little involvement with ward staff. One relative was of the view there was nothing stimulating for people to do that would fill their day on the ward, and nothing moved quickly. Relatives also believed that when referrals were made, progress could take months, which prevented recovery for those on the ward, and they became stuck and

felt helpless and hopeless. We heard how this did not just affect the mental health of the person on the ward, but that of the whole family who felt they could offer nothing to help their family member.

We spoke with members of the MDT who told us “nursing staff do an excellent job and are highly skilled”. We also spoke with staff who informed us that they “feel anxious” working on the ward at times, due to the pressure of the job and having more people on the ward than there should be, with two extra beds, as well as often having people from the ward boarding elsewhere. We were also told of the pressure and demands staff felt trying to provide safe, compassionate care. We were told that staff were sometimes worried for their own physical safety on the ward due to how unwell individuals on the ward could be. We were also told that staff were often required to go off the ward, to support other wards who needed assistance, leaving Craiglockhart Ward short staffed for that period. We also heard from staff of “near misses” on the ward, despite the nursing team always attempting to provide dedicated care to those in the ward.

We heard that during our visit, a group of staff had written to the Board in relation to their concerns. They had also met with relevant others and were awaiting feedback about the matters they raised, not least the continual use of both the interview room and activity room as bedrooms on the ward. We also heard at the feedback meeting that this was being escalated by others.

Care, treatment, support, and participation.

Care records

Information in relation to an individual’s care and treatment was held electronically on TrakCare, which was easy to navigate.

We were pleased to see that most of the information recorded in the care records was detailed and we found comprehensive information on the nursing interventions individuals required throughout the day. We saw several one-to-one interactions recorded that had taken place between individuals and staff and these explored the individual’s feelings and views. The recording of these interactions were comprehensive and person-centred.

We were pleased to see comprehensive recording about the care provided by most members of the MDT. The care records were personalised, outcome and goal focussed and included forward planning. We were encouraged to see regular and comprehensive reviews of individuals by their consultant psychiatrists.

In reviewing the care records, we did not find any recording of activities; we found recording of the activities in the care plan. We would prefer to have seen information on activities recorded in care records, so that it was easily found, along with the rest

of the MDT's information. We discussed this at the feedback session on the day of the visit, and it was agreed this would be beneficial.

During our visit we noted individuals in the ward experienced elevated levels of stress and distress which increased clinical risk, due to high levels of verbal and physical aggression. We were pleased to note that the MDT were actively involved in providing the support, care, and treatment to individuals at these times.

We saw that physical health care needs were being addressed and followed up appropriately. The medical reviews completed by junior doctors were of a high standard and included comprehensive information that was personalised and detailed forward planning for care and treatment.

Care plans

We reviewed the care plans which were stored electronically on TrakCare. We found the nursing care plans in Craiglockhart Ward to be of a good quality and evidenced the individual's care goals and outcomes. The care plans we reviewed were person-centred, detailed, and strengths-based, with clear goal or outcomes focussed interventions. We also found safety plans that were robust.

We were disappointed to see and hear that there had been limited progress in promoting participation with people on the ward who were receiving care. Most of the individuals that we spoke with were unaware they had a care plan and informed us that they had not been involved in completing this or in giving a view on their care and plans for recovery. Nor did they receive a copy of their care plan to fully focus on what they were working towards with the staff on the ward.

The individuals we met with informed us that they did not attend MDT meetings and did not feel involved in any discussions about their care and treatment. Individuals told us that they would like to be more involved in decisions about their care and give a view on what would be of benefit. This was raised during the last Commission visit in 2024 and the lack of progress in promoting individuals' participation concerned us. Craiglockhart Ward was not actively aligning with the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) principle of participation, which encourages and allows people to be involved in decisions about their care.

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

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

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

Discharge planning
We found discharge planning information to be limited. While there was evidence that recorded the MDT discussion and decision making, detailing robust and comprehensive discharge information and planning, most individuals we spoke with were unaware of any discharge planning for them.

We also heard from some that there was insufficient discharge planning, leading to them feeling scared, unsupported and worried about transitioning back into the community. We would have expected discharge planning to be robust, individualised and involve the community mental health or social work teams, as required. When planning takes place, it should create an opportunity for individuals to discuss safety plans and the support they require that would support a successful and seamless discharge and recovery. Unfortunately, we did not find evidence of discharge planning that promoted smooth transitions and positive discharges for people on the ward.

Recommendation 2:
Managers must develop a discharge planning approach which involves the individual and other relevant parties, such as carers and community staff to improve discharge outcomes and give the individual confidence in the discharge experience.

Risk Assessments
The risk assessments we reviewed were comprehensive and detailed. The risks were clearly recorded with a plan to manage each identified risk. We found regular review of the risk assessments and evidence of changes made to update the risk assessment following review and in response to the individual's progress or increased risk.

Multidisciplinary team (MDT)
There was a wide range of disciplines either based on the ward or available when needed. In addition to medical and nursing staff, the MDT comprised of an occupational therapist, psychologist, and art therapist. We were pleased to hear about the role the psychologist had delivered in promoting a differential assessment pathway to support individuals when needed. We heard from staff of regular input, discussion, and liaison that supported assessment and reviews of physical health care needs, with the speech and language team and dietician service being involved when this was needed.

We met with the art therapy staff on the day of the visit. We heard that art therapy was offered two days a week on the ward in a group and individual basis. The group supported individuals to work creatively to develop alternatives ways of expressing emotions, relating to others, communicating and problem solving. In addition to group work, art therapy was available on a one-to-one basis for individuals that they would benefit from this therapeutic intervention; this required to be ratified by the MDT.

There was a designated consultant psychiatrist for the ward, who attended the weekly MDT meetings. Also, in attendance at the meeting were medical staff, nursing staff, pharmacy, psychology, occupational therapy and at times, art therapy. In addition to these meetings, we heard that various other MDT meetings took place due to the ward having individuals boarding from other wards.

The MDT meetings were recorded on a mental health structured ward round template and held on TrakCare. The template had headings relevant to the care and treatment of the individuals in Craiglockhart Ward. On review of the MDT meeting paperwork, we found that most of these records were comprehensive and contained detailed recordings of the MDT discussion and decisions that promoted a holistic approach to the individual's care. We did however find that attendance and involvement of the individual at the meeting were not always recorded.

There was also no evidence of carer or relative involvement, nor from any external supports such as community mental health team or social work, which would have been important, especially at the MDT meetings when discharge was planned. This would have strengthened the discharge planning for individuals and promoted confidence in after care from hospital for those being discharged.

We again discussed the importance of promoting the principle of participation and supporting all individuals in Craiglockhart Ward to participate as fully as possible in any decisions made. The SCN and DND agreed that given the feedback from the individuals during the visit, a review of the current MDT meeting arrangements would be undertaken to consider how the participation of all individuals could be increased.

Recommendation 3:
Managers should ensure individuals are supported to have meaningful participation in MDT meetings to ensure they are empowered to be involved in discussions and decisions about their care and treatment. This participation should be recorded in their clinical record.

Use of mental health and incapacity legislation

On the day of our visit, 11 individuals in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). We found the forms relating to each person's detention stored electronically on TrakCare.

We were pleased to note from the files that we reviewed that there was evidence of legal representation and advocacy involvement to support individuals in understanding their legal status and how to exercise their rights. However, the individuals we met with during our visit had a mixed understanding of their detained status under the Mental Health Act and of their rights regarding this.

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

We reviewed the medication that was prescribed for all individuals, as well as the authorisation of treatment for those subject to the Mental Health Act. We found that for individuals who required T2 and T3 certificates, these were in place and that the medication recorded corresponded with the prescribed treatment.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act 2000 (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. From the files we reviewed, we did not find the need for a section 47 certificate to be completed.

Rights and restrictions

Craiglockhart Ward continued to operate a locked door, which is appropriate with the level of risk identified with the individuals on the ward. We were pleased to see the ward had a locked door policy displayed at the entrance door.

We made a recommendation after the previous visit in relation to improving the delivery and provision of information of rights-based care and recording this in individuals' care plans. We were disappointed to see that there had been limited progress on this recommendation. The individuals we met with had mixed knowledge of their rights. Some individuals did not know they were detained and had no awareness of their rights in relation to the detention.

We were informed that each detained individual received a letter from medical records following detention under the Mental Health Act that included information on their detained status and their rights in relation to this. However, for some individuals, this was insufficient in supporting their understanding and knowledge of rights and more proactive work was required.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where an individual is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. One individual was specified on the day of the visit. Where specified person restrictions were in place, we found a comprehensive reasoned opinion and regular review of the restrictions in place.

When we are reviewing individuals' files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under s275 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. One person had an advance statement in place when we visited. Some of the individuals we spoke to were aware of advance statements however, had chosen not to complete one. Others were unaware of advance statements.

It was clear from reviews of the individual files and during discussion with some people that they were not at a stage in their recovery to make decisions on their care and treatment. We were pleased to hear that the health board were promoting advance statements and there were another seven advance statements being completed by one of the two student nurses who had previously been NHS Lothian staff but were being financially supported by the Board to complete their nurse training.

We were told that advocacy was provided regularly in the ward by the local advocacy service. We were told that advocacy attended the ward on request and provide a good service to individuals who wished to engage with them. We were pleased that all the individuals we met with on the day of the visit either had or had been offered advocacy support.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

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

Recommendation 4:
Managers should ensure that information on rights is easily available and visible throughout the ward and that rights-based care is delivered to individuals and recorded in their care plans.

Activity and occupation

We heard and saw evidence of activities that were available to individuals in Craiglockhart Ward on the day of our visit. A sheet with a range of activities which were being undertaken by health care support staff had been placed on everyone's bedroom door earlier in the morning. This was a new addition to the care and support provided to individuals on the ward and was put in place as the activity co-ordinator post remained vacant.

This approach had upset some individuals who believed it had been put in place to coincide with the Commission visit. The individuals we met with told us that they would prefer that activities took place in a dedicated activity space. Some individuals told us that they did not always attend activities as they found it too challenging to attend the communal ward space as it could feel "intimidating and loud."

We heard that the space given to activities did not provide a therapeutic environment. There were often the competing demands of other individuals who were not engaging in the activity who were making tea, watching TV or meeting family in the same space.

We have made a recommendation on earlier visits that there should be a dedicated activity space in the ward. We were disappointed that this still had not been progressed and the situation remained that there was limited and inappropriate space for individuals to engage in activity. Individuals were clear in their view that the lack of opportunity to engage in regular activity negatively affected their experience and opportunity to recover while in Craiglockhart Ward. They also told us they often found themselves ruminating, feeling bored and isolated in their bedrooms. Some staff also reported that the lack of therapeutic space negatively affected the quality and type of activities that could be offered, which had an impact on people's experience of support, care and treatment in Craiglockhart Ward.

Recommendation 5:
Managers must progress the provision of a dedicated space in the ward for the purpose of therapeutic activities.

The physical environment

Craiglockhart Ward appeared quite clinical, and the environment had not been softened to make it appear more inviting. It did not feel welcoming or homely and did not feel like a therapeutic environment.

The lounge and dining area were situated at the entrance of the ward. This was the only area that individuals could use as a communal area. On the day of our visit, this area was busy. It was being used as an activity space, and also by individuals who wished to watch the television.

We noted that the same communal space being used by individuals to meet with their families. This did not feel like a calming and supportive environment, and we could see that it could be detrimental to both visitors and the individual as there was no ability to speak privately with family. Relatives informed us that this could be distressing and unsupportive for their family member.

Recommendation 6:
Managers should consider reinstating a room to allow individuals to meet with their families and professionals out with their bedrooms in a setting that is calm, relaxed and offers a degree of privacy.

We found individuals openly vaping in this communal area and corridors. When we asked about this, individuals and nursing staff informed us this was normal practice and vaping on the ward or in bedrooms was allowed. We discussed with the DND and SCN at our feedback session on the day. They advised that vaping was not allowed on the ward and informed that more proactive approaches would be taken to support the implementation of the no-smoking legislation, such as non-smoking signage in the ward, and the provision of nicotine replacement therapy. They told us that smoking cessation support was available.

Recommendation 7:
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.

We were pleased to see individuals were able to use the kitchen facilities to make a hot drink and snack. This was however next to the small communal area where an activity was taking place during our visit. There was an outside courtyard that individuals could use each day until midnight. On occasion during the visit, there was a high volume of noise in the communal area of the ward.

We were able to see some of the individuals' bedrooms. The bedrooms viewed had ensuite facilities and were personalised.

There had been concerns raised in the earlier two Commission visit reports in relation to the use of the dedicated activity room in the ward as a bedroom. We found that when we visited the activity room it still had a surplus bed in it. This room did not have washing or toilet facilities, compromising the individual's right to privacy and dignity. Although we recognise the national shortage of mental health beds, we

do not consider using the activity room to be appropriate or safe as an individual's bedroom and have significant concerns about this ongoing practice.

We also found one of two interview rooms being used as a surplus bedroom which also had no washing facilities, nor did it have facilities to store clothes and other items. We found individuals' items stored in plastic bags, which could present further risks in the ward.

We heard that some individuals admitted to Craiglockhart Ward board from other wards. We heard that they return to Craiglockhart Ward during the day, and they have no dedicated bathroom or private bedspace. We were concerned that the regular change in care arrangements and environment could be unsettling and negatively impact on the consistency of care, treatment, and recovery for those who are boarding in other wards.

Recommendation 8:
Managers must adhere to the Mental Health Act principle of reciprocity and ensure they fulfil their obligation to provide safe and appropriate services for all individuals, including those subject to mental health or incapacity legislation.

We raised concerns over boarding arrangements with the SCN and the DND on the day of the visit. We were told that due to the current demand for beds across the hospital site, individuals were asked to board in other wards overnight. We were told that senior managers were aware of the negative impact boarding had on individuals and all efforts were made to adhere to NHS Lothian bed management policy.

We were concerned to hear that despite a 12-bedded surge ward being created some time ago to deal with demand, the situation had not improved, and surplus beds were still being used consistently across the site to meet demand. The Commission would be keen to be kept abreast of any development in this area and the plans for the use of surplus beds in Craiglockhart Ward.

Recommendation 9:
Managers must review current bed management and boarding arrangements to ensure that the safety, welfare and well-being of every individual admitted to the ward is prioritised.

Any other comments

We were pleased to hear of an area of good practice in the ward. The full-time psychology post, which was shared between Craiglockhart Ward, and another ward had been of benefit. Individuals on the ward had a psychology assessment and those who would benefit from a differential pathway/autism assessment had one completed while in the ward.

We heard this post worked closely with the consultant psychiatrist and the MDT. All of the staff we spoke with commented on the positive difference this post had made for people who were admitted to Craiglockhart Ward and the care and treatment they received.

Summary of recommendations

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

Recommendation 2:
Managers must develop a discharge planning approach which involves the individual and other relevant parties, such as carers and community staff to improve discharge outcomes and give the individual confidence in the discharge experience.

Recommendation 3:
Managers should ensure individuals are supported to have meaningful participation in MDT meetings to ensure they are empowered to be involved in discussions and decisions about their care and treatment. This participation should be recorded in their clinical record.

Recommendation 4:
Managers should ensure that information on rights is easily available and visible throughout the ward and that rights-based care is delivered to individuals and recorded in their care plans.

Recommendation 5:
Managers must progress the provision of a dedicated space in the ward for the purpose of therapeutic activities.

Recommendation 6:
Managers should consider reinstating a room to allow individuals to meet with their families and professionals out with their bedrooms in a setting that is calm, relaxed and offers a degree of privacy.

Recommendation 7:
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.

Recommendation 8:
Managers must adhere to the Mental Health Act principle of reciprocity and ensure they fulfil their obligation to provide safe and appropriate services for all individuals, including those subject to mental health or incapacity legislation.

Recommendation 9:
Managers must review current bed management and boarding arrangements to ensure that the safety, welfare and well-being of every individual admitted to the ward is prioritised.

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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