Mental Welfare Commission for Scotland

Report on unannounced visit to:

St John’s Hospital, Regional Eating Disorder Unit (REDU),
Livingston, EH54 6PP

Date of visit: 4 March 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

The Regional Eating Disorders Unit (REDU) is a specialist, 12-bedded unit that provides care and treatment for individuals with eating disorders from NHS Lothian, NHS Fife, NHS Forth Valley, and NHS Borders.

The unit is supported by a specialist multidisciplinary team (MDT) of nursing, medical, occupational therapy (OT), physical health, psychology and dietetics who offer a blended and comprehensive approach.

Admission to REDU is generally via a referral from the community eating disorder teams who have requested a planned admission. Individuals and relatives/carers are provided with information about the unit prior to admission; this includes a video of the environment and what inpatient support is available. However, there are times when admissions are unplanned, when care and treatment is required more urgently.

On the day of our visit, there were 11 individuals on the unit and one vacant bed. We heard and saw that one individual’s discharge had been delayed due to lack of community care provision.

We last visited this service in July 2023 on an announced visit and made recommendations on increased participation of the individual in their care and treatment, ensuring care plans were person-centred, ensuring any restrictions were reviewed regularly, that rights-based care was delivered to individuals in the unit and structured activities were regularly available.

The response we received from the service reported that a new care plan template was being implemented to support person-centred care planning and increase participation of the individual, restrictions would be reviewed weekly at the MDT meeting, rights information would be included on pre-admission information and as part of care planning, activities would be recorded as part of the care plan and reviewed monthly with the individual.

On the day of this visit, we wanted to follow up on the previous recommendations, meet with individuals, staff and relatives/carers, as well as looking at the care and treatment being offered in the unit.

Who we met with

We met with eight people and reviewed seven sets of care records. We did not meet any relatives/carers on the day of the visit. However, we offered to contact relatives/carers following the visit, but no relatives/carers reached out indicating they wished to speak with the Commission.

We spoke with the senior charge nurse (SCN) and nursing staff and OT on the day of the visit. We had a telephone call with the consultant psychiatrist in the days following the visit.

In addition, we contacted advocacy services following the visit.

Commission visitors

Kathleen Liddell, social work officer

Dr Juliet Brock, medical officer

Anne Buchanan, nursing officer

What people told us and what we found

The individuals we spoke with on the day of the visit provided positive feedback about their care and treatment in REDU. Feedback included, “staff are supportive, hard-working and committed”, “staff are kind, caring and take the time to listen to me”. One individual reported “all staff I work with have a very good knowledge of eating disorders”, another individual told us that the care they received was “specialised eating disorder care and support”.

We heard from some individuals that when bank staff were used, there was a noticeable difference in their level of skill and knowledge in eating disorders and they preferred their care to be provided by permanent REDU staff. All individuals told us that staff were available to them, and they were offered regular one-to-one support from various members of the MDT, which they benefitted from.

Many of the individuals that spoke with told us that their experience of admission was “stressful” and many of the individuals spoke about “not remembering” being admitted into REDU and the initial days of admission, due to either high levels of stress and/or being “extremely unwell”.

The individuals we spoke with told us that input from the full MDT had provided them with opportunities to receive specialist, skills-based interventions as well as holistic care based on a psychological model of care that supported the recovery of their eating disorder, mental and physical health.

Most of the individuals were aware of their care plan with some reporting that they had participated in the completion of it. We heard from other individuals that they were unaware of their care plan and had not been involved in their care planning, leading to a view that their care was not always personalised or person-centred.

Some of the individuals we met with raised that they felt there were high levels of restriction in place, especially for informal patients. We heard that every week, individuals submitted ‘requests’ to the MDT, prior to the MDT meeting. Many individuals told us that they felt “frustrated” when the request was not agreed at the meeting. We heard from many that they did not feel they were provided with a clear rationale from this meeting as to why the decision had been made and would prefer to have increased engagement with and involvement in the MDT decision-making process. We also heard that their perceived lack of communication and input into the MDT meeting caused anxiety about future planning, especially in relation to expectations on the individual which were discussed at the meeting.

All individuals that we spoke with told us that there was not enough structured activity in REDU. We heard that when groups did run, they were “good and beneficial” however, there were days when there were no structured groups resulting in individuals feeling “bored” and the “long days” having a negative impact on their mental health, as the lack of distraction could lead to “ruminating on my eating disorder”.

Although we did not meet or speak with any relatives/carers during the visit, we were pleased to see that where consent was provided by the individual, family and carers were involved in review meetings and had regular contact with the MDT.

We heard that there was various support available for relatives/carers including face-to-face and online support groups, including organised walking groups, which we saw advertised on the family room noticeboard. We saw that there was a good level of information available to carers in REDU that provided information on issues such as benefits.

Throughout the visit we saw kind and caring interactions between staff and individuals. Staff spoken with knew the individuals on the ward well and appeared committed and motivated to support the individuals in REDU. It was encouraging to hear that staff time was prioritised to allow them to spend time with people on a regular basis to support building therapeutic relationships.

We met with various members of the MDT during the visit. All staff spoken with told us that they enjoyed working in REDU and felt supported to undertake their role. We heard from this group of staff that they were provided with excellent ongoing training opportunities which supported them to provide specialist and skilled care to the individuals in REDU.

We observed a positive working culture that the SCN has promoted in REDU. The unit had had some changes in the leadership team which could be anxiety provoking for staff, but nevertheless, every staff member we spoke to told us that they felt supported by the SCN.

We were pleased to hear from newly qualified staff that they had been provided with an “excellent” induction programme which included training, practical support and reflective practice. We heard from staff that the team in REDU was “brilliant” and that this enabled staff to feel happy and content at work. We were informed that staff were offered reflective practice from psychology and found this beneficial.

We heard that staffing in REDU was fully recruited and that there was a good level of experience and skill mix in the staff team. We were pleased to hear that the use of bank staff was minimal and that there was a consistent approach to the care provided to individuals in the unit.

Care, treatment, support, and participation

Care plans

Care plans are a tool which identify detailed interventions that ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

We made a recommendation during the previous two visits that care plans should include increased participation from the individual and contain personalised information that reflected the care needs and identified clear interventions and care goals. We were disappointed to see that limited progress had been made and the new care plan template the service had referred to in the recommendation response following the previous visit, had not been implemented.

Of the seven care plans reviewed; we found them to be of mixed quality. We found some good examples of care plans that evidenced participation from the individual which supported individualised, strengths-based and person-centred care. Other care plans reviewed did not show the participation of the individual which was reflected in feedback from individuals.

In one care plan, the individual was referred to as “the patient” throughout the care plan, which was not supportive of a person-centred approach to care, treatment and support. A lack of participation from the individual does not support mutual regard or an equitable relationship between the individual and the care team, and we would prefer that all individuals are encouraged to participate in their care plans.

We found that many of the care plans reviewed lacked detail, as well as clear and attainable care and treatment goals. The care plans did not record comprehensive information on what interventions were required to achieve the assessed outcomes and who was responsible for providing the support. All care plans reviewed were completed by nursing staff therefore lacked a fully integrated MDT approach to care planning. We would prefer that all members of the MDT be involved in care planning to support a consistent holistic approach and promote a strengths-based model of care. We discussed our findings with the SCN on the day of the visit and heard that NHS Lothian were implementing a new person-centred care plan. The service hoped this would improve the quality of the care plans and support a more person-centred approach to care and support planning. We look forward to seeing improvements on our next visit.

We were unable to see regular and comprehensive reviews of the care plans. The reviews that had taken place did not evidence robust information including summative evaluation regarding the efficacy of targeted nursing intervention, as well as the individuals’ progress.

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.

Given the lack of progress and improvement in the quality of the care plans, we are repeating the recommendation we made following our previous two visits.

Recommendation 1:
Managers should ensure that care plans are person-centred, contain individualised information, reflect the care needs of each person and identify clearly intervention and care goals.

We saw that for those individuals approaching discharge, the discharge planning was comprehensive, person-centred and holistic, including involvement from the individual, their family and community services. We heard that due to REDU's regional remit that involved providing care and support to four NHS boards this could impact on discharge planning due to differences in community care provision. Some of the NHS boards had more intensive community support which promoted and supported expeditious discharge.

We saw that physical health care needs were being addressed and followed up appropriately by medical staff. The completed medical reviews were of a high standard.

We found the risk assessments that we reviewed to be of mixed quality. Some of the risk assessments recorded protective factors, stressors and a risk management plan that detailed how the risk should be managed and the interventions required. These risk assessments evidenced review of the risk assessments and changes made to the management plan to reflect either new or reduced risk.

Other risk assessments lacked detail on the identification and management of risk. We were concerned that some of the risk assessments for people who were admitted informally recorded restrictions being in place since admission, they lacked robust detail and a clear rationale for the requirement for this level of ongoing restriction, making it difficult to ascertain if the risk assessment remained proportionate. We found that these risk assessments had not been reviewed regularly and did not reflect the current information in care records.

Care records
Information on individuals' care and treatment was held electronically on TRAKCare. We found this easy to navigate.

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

The information recorded in care records was mainly of a good quality. The care records reviewed were detailed, strengths-based, personalised and intervention focussed. We were unable at times to find clear links between the care plan outcomes and the information recorded in the care records. We would expect the information recorded in care records, especially when there is evidence of changes to the individuals' circumstances, to be updated in the care plans.

We were pleased to see that all members of the MDT recorded in care records and found good examples from the medical staff, physiotherapist, dietetic staff and OT of comprehensive documentation that recorded positive examples that promoted a holistic approach to the individuals' care. We were pleased to see regular and comprehensive review of individuals by the consultant psychiatrist and speciality doctors.

There was evidence of frequent one-to-one interactions between individuals and all members of the MDT. Individuals told us that they met with their key nurse and other members of the MDT regularly and found this interaction to be beneficial. The one-to-one interactions reviewed were of a very high standard. We saw open and transparent discussions taking place between individuals and staff regarding care planning and areas of care individuals found challenging. We were pleased to see that on these occasions, the interactions between the nursing staff and individuals were supportive.

Nevertheless, we were disappointed that these conversations did not always extend to rights-based discussions, especially as many of the issues raised by the individuals were in relation to concerns over restriction. We would have expected these discussions to include information on what the individuals' rights were and how rights could be exercised.

We were pleased to find that the case records included regular communication with families and other professionals. We reviewed some care records that recorded extensive discussions between staff and relatives/carers on issues, such as pass and discharge planning, that was clearly causing families some anxiety. We were pleased to find that on the care records reviewed, the views of the families/carers were clearly recorded and communicated to the other members of the MDT.

Multidisciplinary team (MDT)

REDU had a broad range of disciplines either based in the unit or accessible to them.

In addition to nursing staff, there was one full time consultant psychiatrist, two speciality doctors, a full-time dietitian, dietetic support worker, an OT, physiotherapist and psychologist. We were pleased to hear that the vacant psychologist post during the previous visit had recently been filled and heard the psychologist was putting a plan in place that included psychological therapies for individuals and training/support for staff.

REDU continued to have a consultant physician attending the unit on a regular basis to review individuals' physical health needs. If any of the individuals required increased support for physical health care needs, there was a robust and efficient pathway to transfer people to a medical unit. Staff from REDU remained involved with individuals during this time and offered support at mealtimes, if required.

The MDT met weekly in the unit, although Microsoft Teams was also used to host the MDT meeting, which ensured greater participation and involvement from external agencies. We found detailed and comprehensive recording of the MDT discussion and decisions recorded on the structured MDT meeting template. Most members of the MDT either attended the meeting or provided information in advance. It was clear that everyone in the MDT was involved in the care of the individuals in REDU and were committed to adopting a holistic approach to care and treatment.

We were disappointed to see that there was not always evidence of clear links between care plan outcomes and MDT discussions and decisions. We were able to see from the MDT recording that some of the individuals had made progress which then had an impact on the level of care and support required, however this information was not always updated in care plans and/or risk assessments. We would expect any changes to care and support to be reflected in care planning records.

We heard, and saw, that individuals were invited to attend the weekly MDT meeting. Prior to the meeting, individuals were provided with a 'request form' to complete. Individuals recorded requests in relation to their care and treatment they wished the MDT to consider. The request forms we reviewed mainly requested the MDT to consider passes out the unit or increased pass time.

The feedback from most of the individuals we met with was that although they attended the weekly MDT meeting, they did not always feel fully involved in discussion and decision-making regarding their care and treatment. We were told by individuals that they mostly attended at the end of the meeting and were generally provided feedback as to whether their requests had been agreed by the MDT.

We heard and saw that individuals were given a written feedback form from the meeting. We did not find that the recorded information provided individuals with a comprehensive rationale as to how the MDT had reached their decision, which many individuals found unsatisfactory. We could see from our review of the MDT record on TRAKCare the MDT's justification for the decisions it reached, however this information was not reflected on the feedback sheet given to the individuals and we could understand why individuals were not satisfied with this arrangement. We raised this with the SCN on the day of the visit and were told that the current arrangement would be reviewed.

In addition to the weekly MDT meeting, there was a four-weekly review that the individuals, MDT, relatives/carers and community teams attended, where each person's care, treatment and discharge planning was reviewed.

Use of mental health and incapacity legislation

On the day of the visit, five individuals were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). All documentation relating to the Mental Health Act was electronically stored on TRAKCare and easily located.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

Anybody who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a person had nominated a named person, we found this stored on TRAKCare.

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.

We reviewed the section 47 form completed and found that there was no treatment plan in place. We raised this with the senior specialty doctor who agreed to review the section 47 certificate as a matter of urgency.

Rights and restrictions

REDU continued to operate a locked door policy. The Commission highlighted in the previous two local visit reports concerns in relation to the specific criteria for admission to REDU, particularly a consent form that individuals were asked to sign giving their permission to some restrictions being in place at the initial stages of admission.

We had concerns that the consent form was overly prescriptive, was not tailored to the needs of the individual, and placed excessive levels of restrictions on all individuals, especially those who were not detained under the Mental Health Act. We were also concerned that individuals may be unable to give fully informed consent at the point of their admission, given their high anxiety levels and cognitive ability which may have been negatively impacted and impaired by the effects of starvation.

We were pleased to hear that the service had reviewed the consent form and replaced it with ‘recommendations’ for individuals to follow during initial stages of admission. We were told that the recommendations were in place to reduce risks associated with treatment and recovery from an eating disorder. We reviewed the new documentation and saw examples of the recommendations which we noted were the same restrictions in the previous consent form, mainly individuals agreeing to their bathroom doors being locked and no unaccompanied time off the unit.

Although we acknowledged that the service had made attempts to promote rights-based care by replacing the consent form with recommendations, we remained concerned that on review of the care records, we were unable to see clear MDT rationale for decisions in relation to some of the restrictions in place. We were not satisfied that all restrictions were proportionate to the risk factors identified in the risk assessment, that some restrictions did not reflect the current and improved presentation of the individual recorded in MDT documentation, nor did they support a positive risk-taking approach.

An example of this was where we found that an individual who had been admitted to the unit informally had not been out on unaccompanied pass for a prolonged period of time (eight weeks), although care records indicated progress in relation to increased weight, body mass index (BMI) and improved mental state. We felt that this restrictive approach did not acknowledge progress, nor support positive risk taking.

We were concerned to hear that individuals were not consistently provided with a rationale for restrictions in place and did not feel ‘comfortable’ to challenge decisions or exercise their rights due to fears over the consequences for them, which they felt may include either detention under the Mental Health Act or discharge from the unit. We were concerned that the approach to these restrictions did not appear to be compatible with the core principles of the European Convention on Human Rights, and in particular, article 5, right to liberty and security and article 8, right to respect for private and family life.

Recommendation 2:
Managers must ensure that all restrictions placed on individuals throughout their admission are legally authorised, reviewed regularly and discussions regarding restrictions and consent are clearly documented.

When discussing restrictions with some individuals, specifically people admitted to the unit on an informal basis, we heard that they did not agree nor fully consent to various aspects of their care plan and risk assessment. On review of the care records, we were concerned that documentation such as pass planning recorded the consent of the individual however, this did not reflect the views of the individuals spoken with. Whilst we recognised the challenges of the service balancing the individual’s rights against the assessed risks, we remain concerned that the current approach does not take account of the key elements required to promote rights-based care.

We were also concerned that the documentation on decisions around restriction, did not record the fully informed consent of the individual. We would expect care records recording restrictive practice to maintain detailed documentation of the consent process, including information provided to individuals, aspects of any supported decision making required, any questions the individual had and the service response.

Recommendation 3:
Managers must ensure that rights-based care is delivered to individuals and recorded in care plan and should consider ways to improve staff understanding of this.

There should be regular review to ensure that specific discussions with individuals regarding restrictions are comprehensively recorded, including whether they provide consent and that they have been made aware of their rights, both when they are informal and when detained under the Mental Health Act. We discussed these concerns with the SCN on the day of the visit and with the consultant psychiatrist following the visit, who agreed that ongoing work was required in REDU to find a more balanced and rights-based approach to restrictive practice.

We were pleased to see improvements had been made in providing and displaying information on rights in REDU. We saw rights-based information on QR codes on all bedroom doors and this information was also available in paper form. We saw that information on rights was included in the pre-admission pack, with contact details for advocacy.

A weekly community meeting took place in the unit. We heard from most individuals spoken with that they found this meeting supportive and useful. Some individuals told us they had raised some unit issues at the community meeting and found that the forum, facilitated by staff, had enabled them to find solutions to the issues they were experiencing.

Continuous intervention (CI) was in place for two individuals. We reviewed the documentation for both individuals and were unable to find either a care plan or MDT documentation that recorded the purpose for implementing CI.

We found that CI information was recorded in the daily care records. The quality of information reviewed was variable and we were unable to find documentation that recorded clear decision making as to why CI was required and regular review to assess its effectiveness and determine if it remained necessary. This practice does not align with 'NHS Lothian's Standard Operating Procedure: The Practice of Continuous interventions in Mental Health Units' that recommends that continuous intervention should be reviewed regularly to assess its effectiveness and promote a framework of practice that is proactive, responsive and personalised. We were disappointed to find limited review of continuous observation being undertaken.

Recommendation 4:
Managers should ensure that the need for enhanced observation is clearly recorded, regularly reviewed and staff have access to and are conversant with the observation policy.

When we are reviewing individuals' 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 of an advance statement.

Advocacy is provided in the unit by Consultation and Advocacy Promotion (CAPS), who provided a specialist eating disorder advocacy service and The Mental Health Advocacy Project (MHAS) who mainly provide collective advocacy. We saw and heard that many of the individuals in the unit had regular contact with CAPS.

We made contact with CAPS and MHAS following the visit and asked if there were any themes raised by individuals regarding rights, care and treatment in the unit. We were told that issues in relation to restrictive practice and an inconsistent approach from staff was an issue that was discussed regularly with advocacy.

We were disappointed to hear that NHS Lothian had terminated the funding for CAPS to provide a specialist eating disorder advocacy service in REDU, with the service due to end in November 2025. Individuals in REDU will continue to have access to advocacy services however, this will not be as regular which was a concern to the Commission given the concerns in relation to rights highlighted during this visit.

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

Activity and occupation

We made a recommendation in the previous report that there should be more regular structured therapeutic activity available to individuals in REDU. We were disappointed to hear and see that limited progress had been made in the provision of

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

this. Some individuals had activity care plans however, this was inconsistent in the care records we reviewed. We heard from individuals that the lack of activity and structure led to feelings of boredom and frustration.

We did see that various psychoeducation and therapeutic groups provided by members of the MDT, mainly OT and dietetic staff were available. However, these groups were not available to all individuals and generally took place once a week, leaving prolonged periods of time where individuals did not have any structured activity to engage in.

We were told that the activity timetable was under review and that the introduction of psychology to the MDT would provide increased psychological interventions and support a better structure to the provision of activity in the unit.

We saw that the communal sitting room in the unit had a variety of activities available for individuals to engage in including jigsaws, board games and arts and crafts. During the visit, we saw individuals engaging in these activities, especially as part of post-meal observations and saw that staff were available to engage in activity with individuals at these times.

We were pleased to hear that volunteers attended the unit and provided some activity, for example therapet sessions, complimentary therapy, arts and crafts. We heard that further volunteer activity was planned to commence in the unit over some evenings and weekends.

Recommendation 5:
Managers should ensure that structured activities with a therapeutic and well-being focus are regularly available to individuals. Managers should ensure that activity participation is recorded and evaluated.

The physical environment

REDU's environment was bright and spacious. There was a hub area in the centre of the unit that individuals and staff used. The unit also had a family room where individuals could spend time with their relatives/carers. The family room was child-friendly and had various toys for children who visited. The dining room and lounge areas were spacious. The lounge had many activities, such as board games and crafts for individuals to engage in.

There was a laundry room and kitchen for individuals to access and complete their own laundry and meals if appropriate, and if included in the individuals care plan.

The cleanliness of the unit was of a good standard and the decor well maintained. Some areas of the unit had a more clinical feel however, this was balanced with communal areas and individual's bedrooms being more homely with the inclusion of artwork and soft furnishings.

We were able to view some of the individuals’ bedrooms. All bedrooms had en-suite facilities and personalisation of individuals rooms was encouraged. We were told that the anti-ligature required during the last visit had been completed.

Individuals could access a spacious garden area, which had seating areas that created a therapeutic space for individuals.

Any other comments

We are concerned that a number of the recommendations made in relation to this visit were the same as the last visit report and in relation to care planning, this was highlighted in our last two visit reports, with limited improvements made.

We discussed this with the SCN who had an awareness of the ongoing areas of improvement needed and was transparent about the barriers to progress. This level of awareness and transparency demonstrated an ongoing commitment by the leadership team to prioritise identified areas of improvement in order to promote and ensure rights-based care in provided in REDU.

Summary of recommendations

Recommendation 1:

Managers should ensure that nursing care plans are person-centred, contain individualised information, reflect the care needs of each person and identify clearly intervention and care goals.

Recommendation 2:

Managers must ensure that all restrictions placed on individuals throughout their admission are legally authorised, reviewed regularly and discussions regarding restrictions and consent are clearly documented.

Recommendation 3:

Managers must ensure that rights-based care is delivered to individuals and recorded in care plan and should consider ways to improve staff understanding of this.

Recommendation 4:

Managers should ensure that the need for enhanced observation is clearly recorded, regularly reviewed and staff have access to and are conversant with the observation policy.

Recommendation 5:

Managers should ensure that structured activities with a therapeutic and well-being focus are regularly available to individuals. Managers should ensure that activity participation is recorded and evaluated.

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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