Mental Welfare Commission for Scotland

Report on announced visit to:
Royal Cornhill Hospital, Davan and Muick Wards, Cornhill Road, Aberdeen, AB25 2ZH

Date of visit: 30 April and 1 May 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

Davan and Muick Wards are both 20-bedded wards that provide care and treatment for older adults who suffer from a functional mental illness. The two wards receive admissions based on a geographical area; Muick Ward has a catchment area that predominantly covers Aberdeen City, while the catchment area for Davan Ward is Aberdeenshire. Both wards had two surge beds which we were told would be used as and when required, depending on need across the older adult wards.

On the day of our visit, there were 22 people on Davan Ward with no vacant beds and both surge beds in use. There were 21 people on Muick Ward with one surge bed in use.

We last visited Davan Ward in April 2023 on an announced visit when it had been temporarily decanted to Drum Ward; this was to allow progress with the ligature reduction programme of works that had been scheduled across the Royal Cornhill Hospital (RCH) site. At that time, we made recommendations on care planning and the audit of these, the content of multidisciplinary team (MDT) meetings and how outcomes of these meetings were fed back to individuals and that forms authorising treatment should be stored with drug prescription sheets.

Muick Ward was last visited in May 2024 on an announced visit. At this time, we made recommendations on the promotion of advance statements, inclusion of individuals and carers in the MDT meetings and feedback from these, the recording of activities and adherence to covert medication pathways.

The response from the service included comprehensive action plans for both wards, detailing how those recommendations were going to be met. On the day of this visit, we wanted to meet with people receiving care and treatment on the wards and where possible, their relatives. We also wanted to review care records, follow up on the previous recommendations and see how the service was implementing the actions.

Who we met with

We reviewed the care notes of nine people on each ward, six who we met in person in Davan Ward and five who we met in person in Muick Ward. We also met with two relatives in Davan Ward and two relatives in Muick Ward.

We spoke with the service manager, the nurse manager, the senior charge nurses (SCNs), the physiotherapists, members of the nursing team and advocacy workers from both Aberdeen City and Aberdeenshire services.

Commission visitors

Susan Hynes, nursing officer
Anne Buchanan, nursing officer
Tracey Ferguson, social work officer
Audrey Graham, social work officer

What people told us and what we found

At the time of these visits, there were 43 individuals on the wards. We introduced ourselves to some of them and chatted to them throughout the day. We were not able to have in-depth conversations with all those on the ward, because of the progression of their illness. However, others were keen to let us know how their care and treatment was.

Individuals in Davan Ward told us that that they were “happy on the ward”, staff were “nice” “friendly” and “caring”. On Muick Ward, we heard that “everyone respects you”, “the nurses make time for me” and that they were treated with care and compassion. People in Davan Ward highlighted the garden as being “beautiful” and “a peaceful, calm space”.

Individuals in both wards enjoyed the activities offered by the physiotherapists with one saying “we get a good workout here”.

Some of the individuals and relatives in both wards spoke about a lack of involvement in the team meetings and difficulties meeting consultant psychiatrists. They felt the nurses were very caring but couldn’t make decisions on behalf of the team and they were sometimes left waiting to get feedback from the multidisciplinary team (MDT) meetings. Each of the families we met with thought it would be helpful to be more involved in MDT meetings and to meet regularly with their relative’s key worker.

One family in Davan Ward spoke of their frustration at the multiple changes of consultant which, they felt had had a negative impact on their relative’s care.

There were comments about the environment, with some people not liking the open plan design, saying they found it to be noisy, while others spoke about a lack of quiet space. This was echoed by relatives we spoke with on both wards, who stated they would prefer the option of a more private area to visit their family member. Views were mixed on the dormitory accommodation, with some individuals that enjoyed sharing while others would have preferred their own room

From our observations, both wards were calm, and individuals appeared content. Throughout the day we saw positive interactions between individuals and the ward staff. The staff commented that they enjoyed their work, that they found it rewarding and the environment was pleasant. They did comment that the office space could become very warm due to the lack of ventilation.

We heard from staff that both wards were very busy with an increase in clinical acuity. Although designated to admit people with a functional illness, there were several people in the wards with a primary diagnosis of dementia. We heard that this

could cause difficulty in meeting different individual needs, but we were pleased to see how well staff managed this.

Davan and Muick Wards have experienced additional pressure on beds due to the closure of wards specialising in dementia care across RCH and Aberdeenshire, combined with difficulties in discharging people to suitable community facilities. We were told this could result in people boarding in other wards in the hospital, but psychiatrists from Davan and Muick Wards continued to hold consultant responsibility; people who were boarding elsewhere continued to be reviewed at the Davan and Muick Wards MDT meetings. Staff from these wards explained they frequently offered support and advice about managing the needs of older adults to staff from the wards where these individuals were boarding out to.

Both wards told us how they have developed 'shared decision councils' where decision-making groups have taken forward suggestions and proposals made by individuals in the ward, their relatives or carers and staff. There was MDT support for this, with staff using quality improvement methodology to take forward some projects.

The group has helped embed environmental improvements and provide recreational activities for the individuals in the wards. Moving forward, there was an ambition to involve individuals and carers in the group.

Care, treatment, support, and participation

Care records

In both wards, care records were held in both paper and electronic format, with the latter being held on TRAKCare.

Of the care records we reviewed in both wards, most had a detailed nursing assessment which was completed on admission, along with an initial risk assessment and risk management plan. These provided important background information and included relatives' views of risk which provided staff with knowledge of the person's presentation, as well as any risks and an agreed plan of care and risk management.

Across both wards we found instances where these initial risk assessments were incomplete. The initial risk assessment was followed up with a fuller risk assessment recorded on TRAKCare. We found these risk assessments to be detailed and with a comprehensive management plan; we were disappointed to find some of these records had not been reviewed.

In both wards we saw evidence that physical health care had been monitored on admission and throughout the person's journey, with prompt referrals made for further investigations, when required. Some care records had completed 'Getting to

know me' booklets, where there had been input from relatives; these provided information about each individual's background. We found some booklets in Muick Ward hadn't been completed. We would have liked to have seen these booklets being completed as fully as possible as they are important given that they provide a comprehensive view of the person.

Where do not attempt cardiopulmonary resuscitation (DNACPR) forms were in place, we were pleased to see that discussions with the proxy/relative had been recorded by both ward teams.

We wanted to follow up on our previous recommendation regarding care plans in Davan Ward. On our last visit we found that not all care plans were person-centred and holistic; there was also a lack of robust review. On our last visit to Muick Ward, we found some care plans that were co-produced with individuals, were detailed and regularly reviewed; however, some individual's care plans lacked detail and did not have the person's involvement.

We wanted to find out what progress had been made regarding care plan reviews and evaluations, to ensure they remained meaningful throughout the person's journey.

All care records we reviewed showed regular one-to-one sessions between individuals and staff, but we found that the care records could have provided more details as to how the daily care and activity linked with care plans.

In both wards we found that some care plans were well written and detailed, they incorporated all physical, mental health and emotional care needs for the individual, although others lacked detail and were more task orientated. Reviews were not consistently carried out and some lacked the summative evaluation of how the interventions were supporting the individual in achieving the care goal.

We were told by the SCNs in Davan and Muick Wards that monthly care plan audits were being completed although there was a need to focus on the qualitative aspect of the care plan and how it linked to the MDT meetings and care notes.

Recommendation 1:
Managers must ensure for both wards that the regular audit process of the care records includes ensuring care plans are person-centred, reflect and detail interventions that support people towards their care goals, are regularly reviewed, contain summative evaluations, and evidence individual and carer involvement.

Across both wards there were individuals who could present with stressed and distressed behaviours. We found that care plans lacked consideration of the triggers or early warning signs of distress which could allow staff to intervene at an earlier

stage to reduce this. We would hope to see the development of these care plans at our next visit.

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

Multidisciplinary team (MDT)
We were told there had been several changes of consultant psychiatrists, with locums covering this role in several of the localities that Davan Ward covered. This had resulted in a lack of consistency of care and delays in treatment which we heard about from some of the relatives we talked to. The relatives we talked when we visited Muick Ward, where there was a permanent psychiatrist, told us there was excellent communication and treatment.

Staff agreed that where there had been a number of locum consultants in post, there was an impact on some individuals, caused by these changes which staff felt had slowed progress. Staff were hopeful that with the recent recruitment to the consultant psychiatrist post in Davan ward, this would provide consistency for these individuals and their families.

Each ward had a speciality doctor who provided physical health care, and both wards had access to dietetics and speech and language therapy as needed. We heard about the valued contribution occupational therapy (OT) and physiotherapy made to the team and we saw care plans in individual's notes that outlined their care and treatment goals.

We were disappointed to hear from staff that access to clinical psychology services was very limited for both wards. Clinical psychology was available for those individuals with a primary diagnosis of dementia or where an initial assessment had been completed prior to discharge. The Commission visitors thought that with the complex presentations and comorbidity of the individuals in both wards, they would benefit from psychological formulation and treatment. We were told there was a shortage of clinical psychologists, and these posts were currently unfilled in both wards. Having seen the positive impact clinical psychology had on care and treatment, particularly in supporting individuals with stressed and distressed behaviour during our visits to other wards in RCH, we would recommend that recruitment of this discipline continues to be pursued.

Recommendation 2:
Managers should ensure that the wards have dedicated clinical psychology input to inform care and treatment and aid planning individuals' recovery.

We were told members of the community mental health teams would attend MDT meetings where appropriate to support discharge planning. Any individual whose

discharge from hospital was delayed was escalated to the weekly delayed discharge meeting which was attended by all wards, managers and health and social care partnership colleagues.

We reviewed the team meeting records and found them to be of variable quality in both wards. Some had very limited information, while others gave a robust summary of the outcomes and ongoing plans. The MDT meeting record was documented in the electronic notes and a proforma was used which if fully completed, would provide a detailed account of the individual's progress, views and plans to move towards discharge. In both wards we found there were several sections of the document which were not consistently completed.

The weekly reviews we saw in both wards summarised the individual's activity or incidents but did not refer to the previous week's plan and progress towards the goals. In a number of the care records that we reviewed where there were weekly MDT meeting summaries, the same goal had been written for several weeks.

There was a lack of detail about who attended the MDT meetings in Muick Ward, and we would advise that this completed and will review this on future visits. We were pleased to see attendance was recorded for the Davan Ward MDT meetings, which had been highlighted as an area for improvement in our last report.

We found the individual and carer/family views section incomplete in all of the records we reviewed and were concerned about the lack of their involvement in the MDT meetings. The individuals and relatives we spoke to confirmed they did not attend MDT meetings, nor were they consistently asked for their views to be considered at the meeting.

One relative in Muick Ward told us they did receive detailed feedback from medical staff after a meeting, while in both wards, of those that we spoke with, they reported that the nurses would tell them if they asked. We would have expected to see consistent, detailed summaries of these meetings, with plans that were reviewed and included involvement of the individual and their family, along with feedback given to them after each meeting where it was appropriate to do so.

This had been a previous recommendation for Davan and Muick Wards, and we were disappointed not to see more progress in the record of the meetings, the inclusion of individual and relatives' views and the development of a feedback mechanism following the meeting.

Recommendation 3:
Managers must develop a mechanism for Davan and Muick Wards to ensure individuals and/or relatives are able to have their views considered as part of the MDT process, that feedback is given to individuals and/or relatives and clearly recorded in the care records.

Use of mental health and incapacity legislation

We were keen to see how Davan Ward had responded to our previous recommendations that managers should ensure that copies all certificates authorising treatment; T2 and T3 certificates, section 47 certificates, and associated treatment plans were stored with the drug prescription sheet and that where covert medication was in place, review dates were clearly recorded and the ongoing need for covert medication was discussed at the weekly MDT meeting.

On the day of the visit, seven people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) in Davan Ward and eight in Muick Ward. One person in each ward had a welfare guardianship order, five people in Davan Ward and three people in Muick Ward had a power of attorney, and there were eight people in Davan Ward and nine people in Muick Ward who had a section 47 certificate under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act).

We found all documentation relating to the Mental Health Act and the AWI Act, including certificates around capacity to consent to treatment which we found to be in order and easily accessible in Muick Ward. In Davan Ward, while Mental Health Act and certificates around capacity to treat were in order and easily accessible, copies of power of attorney documents were not found in individual's records. This was discussed on the day with the SCN who agreed to ensure copies would in future be stored in individual's care records.

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. Across both wards we found consent to treatment certificates (T2) and associated consent forms and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

Copies of all treatment certificates were kept in a folder in the ward dispensaries, so were readily available for the nurse dispensing the medication to check. We were told by the SCNs that these certificates were regularly audited.

We had made a previous recommendation in Muick Ward that where covert medication pathways were in place, these should be reviewed. We were pleased to see that in both wards, for people who had covert medication in place, all appropriate documentation was in order, with reviews recorded and the care that was provided followed the pathway where covert medication was considered appropriate.

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 the details for this in the person's care

records. However, we heard they were not always fully included in decisions about their care and treatment.

For those people where the AWI Act was required, we found that where the individual had a welfare guardian or attorney, this was documented in their care record.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of 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 all certificates in both wards were completed, included the treatments that were required and there were detailed treatment plans. In one case in Davan Ward, we found the individual's appointed legal proxy had not been consulted by the doctor, which was raised with the team on the day.

Both wards had a display board in the office that provided an overview of all individuals in the ward and where their legal status was recorded. Muick Ward had an system in place to highlight where an individual had a guardianship order, a power of attorney and / or a section 47 certificate. This ensured staff could quickly identify which part of the AWI Act a person was subject to. We recommended on the day that a similar approach would be helpful in Davan Ward to ensure staff were aware where a person was subject to a guardianship order, power of attorney or a section 47 certificate.

Unfortunately, due to the placement of this board in the main staff office in Muick Ward, which was surrounded by glass windows, we found that individuals and visitors could view this confidential information from the lounge area and ward corridor. This had been raised on our last visit when we had suggested to the SCN and managers to either move the board or place a screen over it. They had agreed to address this as a matter of priority to preserve the privacy and confidential information of each individual. A blind had been provided to cover the information, but staff agreed this was not routinely used and an alternative solution would be required.

Recommendation 4:
Managers must ensure that individuals in Muick Ward's right to confidentiality is maintained and no person identifiable information can be viewed by those who do not have authority**.**

Rights and restrictions

The doors to the wards were locked and a policy for this was displayed at the entrance to each ward. Although we felt this was proportionate for those who were detained under the Mental Health Act, the rights of individuals who were admitted to

the wards informally, and who did not require a locked door must equally be fully considered. The Commission's view is that, for those individuals, they should have written information and instruction, if necessary, on how to come and go from the ward. We found individuals were aware of their ability to come and go from the wards and those who had their outside access limited, were either detained under the Mental Health Act or were content with this restriction and did not wish to go out without an escort for various reasons.

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. In Muick Ward we found one person who had an advance statement which had been over-ridden. We found the correct process had been followed for this over-ride and that the Mental Welfare Commission had been informed of this and a second opinion completed.

We were aware that some individuals may not have been able to make an advance statement, but we did not find if this had been discussed at specific intervals during the admission process, as this was not recorded. Advocacy staff highlighted that staff would at times approach them to help write an advance statement; however, sometimes the individual was not keen to do this and did not appear to have an awareness of what an advance statement was. This had been highlighted as a recommendation previously for Muick Ward and we were disappointed there did not appear to be any progress with this.

Recommendation 5:
Managers should ensure that staff in both wards are familiar with their role in promoting the use of advance statements and providing individuals with information and assistance with this. These discussions should be clearly documented within the clinical records, along with a copy of any advance statement.

In both wards, where individuals had been detained under the Mental Health Act, we found they had been provided with information about their rights and had access to advocacy services. Some individuals told us about the support they had received from advocacy in relation to an appeal of their detention and had knowledge about the role of the Mental Health Tribunal. However, this was not the case for all, as the people we spoke to in both wards had varying levels of knowledge about their rights and legal status. This appeared to be influenced by their level of cognitive functioning.

Both wards provided verbal and written information about rights and legal status and had good links with advocacy service, who were based in the hospital. We were pleased to see the involvement of advocacy services when we reviewed individual's

records and during our visit; there were also weekly collective advocacy meetings in the wards. We saw rights-based information prominently displayed around both wards.

The Commission has developed *Rights in Mind.* 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. The rights pathway was displayed on the large board in Muick ward that provided a variety of rights-based information.

Activity and occupation

We heard that the OT and physiotherapist provided activities to the ward and there was an activity planner displayed on the wall in the sitting areas of both wards.

Physiotherapy offered daily group exercises and a daily walking group, which many people told us that they enjoyed. These activities were offered Monday to Friday, and we saw activities happening on the day of our visit.

Mindfulness sessions were offered, and we heard from individuals of how they benefitted from these. There were also mindfulness resources in the quiet room in Muick Ward and we were told by one individual how helpful they found them.

People in both wards told us about their outings with staff and that they enjoyed getting off the ward for a coffee or going to the shops, while an individual in Muick Ward told us they enjoyed their daily walk and had a routine for getting out of the ward. Most individuals we talked to told us that they were offered regular activities.

However, in both wards, some individuals reported that if you did not like exercise the alternative choices were limited, particularly if the person did not have time out of the ward. This appeared particularly problematic in Muick Ward as there was no accessible garden area.

We had previously recommended that Muick Ward should record all offers made to participate in activities and that activities that were undertaken should be documented. We were disappointed to see that it was still not clear if individuals were asked to participate and had declined to take part in activities or if they had not been offered.

Recommendation 6:
Managers should ensure that a full programme of activity is offered across both wards, and continued consideration is giving to employing activity support workers. All offers to participate in activities should be recorded and all activities undertaken are documented and linked to individual care plans.

We were told by individuals in both wards that it could be boring at weekends and difficult to get out of the wards if staff were busy. There were no activity support

workers in either ward, who would have more dedicated time to provide activities both in and out of the wards, across seven days. On our last visit to Davan Ward, we heard that it was hoped the ward would employ an activity worker, but this had not happened. The Commission have seen the benefit of these roles in other wards and feel consideration should be given to these roles.

The physical environment

These newly refurbished wards were bright and spacious, and we were able to see the improved environment with the ligature reduction works completed.

There was a variety of information displayed on the walls of both wards for relatives and carers, such as literature about other organisations. There was also information about the ongoing improvement work, ward audits and feedback from individuals and their families. There were posters up promoting the work of the Mental Welfare Commission and information about our visit to the wards.

The wards had further benefitted from the refurbishment in that the windows opened, allowing fresh air into the ward. Muick Ward was situated on the first floor of the building, with access via a lift to the lower floor, providing access to the hospital grounds. The ward did not have specific garden area, although the SCN told us that it was possible to access Davan Ward's garden area, however this involved walking through Davan Ward. The garden in Davan Ward was well maintained and had several areas that individuals and their families could sit. There was access from the ward to the garden and during the visit we saw how this was enjoyed by the people in the ward, adding to the calm environment.

The wards had a similar mixture of shared dormitories and single en-suite bedrooms. The SCNs told us that they kept male and female dormitories separate and there tended to be four beds to a dormitory, with potential for five beds if the surge beds were required.

Each dormitory had a shower with ample rails for support, as did the single bedrooms. Prior to our visit, we were told about a safety issue that meant there was a requirement for the curtains to be removed from bedroom areas. This had had an impact on privacy, with some bedrooms facing out towards the public paths. Dormitory rooms had curtains round each bed, but this did not provide the degree of privacy we would expect. We were pleased to hear that managers had prioritised finding a solution to providing window coverings and we will follow this up with the service.

Both wards had a separate bathroom with a large bath. Staff in Davan Ward told us this was well used by individuals in the ward, however, the bath in Muick Ward had been broken for several months. We were told this had not worked consistently since moving back to ward following the refurbishment. The SCN told us of the impact of

this on some individuals who were uncomfortable using the showers. We would advise that a solution be found for the ongoing issues with the bath in Muick Ward and will request an update from the service.

There were separate dining and sitting areas on both wards, with ample seating and a few other quieter seating areas in the wards' corridors. Davan Ward had a room that overlooked the garden and provided a quieter area than the main sitting area, although this was kept locked as some items in it were not ligature proof. We felt this space was underutilised, as it was only used for meetings and groups. Consideration should be given to better use of this as an area for visits and as a quiet space should potentially harmful items were removed.

Relatives in both wards told us that they tended to sit in the lounge with their relative during visiting times. Some enjoyed this although we heard from some relatives in both Davan and Muick Wards that they would have preferred more privacy but were unable to access the quiet room. We followed this up with the SCNs and were told that there were other options on the ward to offer a more private space, as opposed to sitting in the lounge with others, but noted that relatives would need to ask for access.

Both wards had a staff wellbeing room, and although small, this was dedicated space for staff to have their breaks on the ward, should they choose to. Each ward had a separate room for the SCNs, however these specific rooms did not have windows that opened, and we heard how it became very hot at times, similar to the staff office. Staff told us that the heat in the office could at times be unbearable.

Good practice

We were told by the SCN in Muick Ward that they were a pilot site for a delayed discharge project 'discharge without delay' with Health Improvement Scotland (HIS). This was showing encouraging results with an individual whose discharge was delayed on the day of our visit in Muick Ward. We noted as part of this process there was proactive discharge planning from admission and consideration of use of AWI Act legislation at an early stage. We look forward to hearing how this work progresses and is rolled out to other wards at our next visit.

Summary of recommendations

Recommendation 1:
Managers must ensure for both wards that the regular audit process of the care records includes ensuring care plans are person-centred, reflect and detail interventions that support people towards their care goals, are regularly reviewed, contain summative evaluations, and evidence individual and carer involvement.

Recommendation 2:
Managers should ensure that the wards have dedicated clinical psychology input to inform care and treatment and aid planning individuals' recovery.

Recommendation 3:
Managers must develop a mechanism for Davan and Muick Wards to ensure individuals and/or relatives are able to have their views considered as part of the MDT process, that feedback is given to individuals and/or relatives and clearly recorded in the care records.

Recommendation 4:
Managers must ensure that individuals in Muick Ward's right to confidentiality is maintained and no person identifiable information can be viewed by those who do not have authority**.**

Recommendation 5:
Managers should ensure that staff in both wards are familiar with their role in promoting the use of advance statements and providing individuals with information and assistance with this. These discussions should be clearly documented within the clinical records, along with a copy of any advance statement.

Recommendation 6:
Managers should ensure that a full programme of activity is offered across both wards, and continued consideration is giving to employing activity support workers. All offers to participate in activities should be recorded and all activities undertaken are documented and linked to individual care plans.

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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