Mental Welfare Commission for Scotland

Report on unannounced visit to:
Royal Edinburgh Hospital, Meadows Ward, Morningside Place, Edinburgh, EH10 5HF

Date of visit: 22 April 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

Meadows Ward is a 16-bedded adult acute psychiatric admission ward for females, with a catchment area for the southwest and southeast areas of Edinburgh.

On the day of the visit, the bed capacity had been increased to 17 beds with the use of one additional bed located in an interview room that would usually have been used for meetings. We were told that some individuals who met the criteria for the ward were boarding in other admission wards across the hospital site due to bed capacity in Meadows Ward.

Furthermore, we were told individuals who met the criteria for admission were also accommodated in the Royal Infirmary of Edinburgh (RIE) emergency department. Where the Royal Edinburgh Hospital (REH) has reached bed capacity, a 'divert protocol' is put in place, individuals will be accommodated in a general hospital with nursing staff for support until a mental health bed becomes available. On the day of the visit, we were told there were three individuals in the RIE waiting transfer to REH to commence care and treatment in a mental health hospital.

For this visit, we wanted to follow up on the seven recommendations we made from our last visit in April 2024. In particular, we wanted to find out if there had been progress made towards inviting individuals to actively participate in care planning, recording of goals and interventions to aid recovery with regular reviews to determine progress. We were keen to find out whether there had been progress in relation to the ward implementing NHS Lothian's 'no smoking policy' and supporting individuals to consider smoking cessation.

During our last visit to Meadows Ward, we were concerned that rooms used for the purpose of meetings and other useful quiet spaces were accommodating individuals as the ward had reached its bed capacity. We were told that the ward had one individual sleeping in an interview/meeting room. We were therefore disappointed to find there had been little progress in terms of ensuring people admitted to Meadows Ward were provided with a bedroom that met their needs and was fit for purpose.

On our last visit, we were aware there was not a structured programme of activities available for individuals and where there had been recreational engagement, we had not been able to locate evidence of this in individuals' care records. The last of our recommendations from this visit for responsible medical officers to ensure that all consent and authority to treat certificates were valid, and that all psychotropic medication was legally authorised.

As with all recommendations, we require an action plan to be put in place by the service that identifies who is responsible for delivering progress and, timescales for completion. We had received a detailed action plan from the service with actions for each recommendation and specific timescales.

Who we met with

We met with eight people and reviewed seven care records. As the visit to Meadows Ward was unannounced, we did not have the opportunity to meet with relatives on this occasion.

We spoke with the clinical nurse manager, the recently appointed temporary charge nurse as the ward was without a senior charge nurse at the time of the visit. We also had the opportunity to meet with staff nurses and the senior management team at the end of the day to provide feedback from our visit.

Commission visitors

Anne Buchanan, nursing officer

Kathleen Liddell, social work officer

Sandra Rae, social work officer

What people told us and what we found

The individuals we met on the day of the visit provided us with mixed feedback about their care and treatment in Meadows Ward.

We heard from the individuals that we spoke with that staff were largely caring and available when individuals needed support. Allied health professionals (AHPs) including occupational therapy (OT), arts psychotherapy and the psychologist were regarded positively by individuals we met with and considered their input as an important part of their recovery.

There were individuals who felt care and treatment was not always consistent. This was because the ward was often reliant on bank and agency staff who did not know individuals well. We heard that this had, at times, left people feeling unsafe and unable to approach bank staff when they required additional support during times of stress and distress.

We asked individuals if they had been involved in their care planning, specifically looking at goals and interventions to aid recovery. Furthermore, we were keen to find out whether individuals were invited to participate in multidisciplinary team (MDT) meetings, reviews and discharge planning. While some individuals had felt included in their care and treatment, this was not the case for everyone we spoke to. We were told in relation to decision making, individuals had not always felt their views were sought, what was important to them and how the service would support their recovery. We were disappointed to receive this feedback as we had made two recommendations from our last visit regarding this.

We had received an update from the service that staff were to receive training in relation to supporting people to be active partners in their care and treatment. Individuals were to be invited to provide feedback to ensure care and treatment met their identified needs and participation was promoted. We met with nursing staff to understand their views about the model of care they delivered to people admitted to Meadows Ward. We were told efforts were made to engage with individuals however, this was often compromised due to staff shortages.

Moreover, where bed capacity had been reached and admissions exceeded the number of 16 beds, nursing staff establishment had not been increased to meet this demand. Nursing staff were routinely moved to support individuals in the RIE as required in the ‘divert’ protocol. We were told the current climate of increasing bed capacity and the ‘divert’ protocol had a consequence on inpatient services including positive engagement to meet the needs of people admitted to Meadows Ward.

We were advised that in an attempt to have a core establishment of nursing staff focussing on patient care in the ward, individuals admitted to RIE were mostly

supported by bank/agency staff however, when this was not possible, ward-based staff would be re-directed to RIE.

Care, treatment, support, and participation

Following our last visit to Meadows Ward we made two recommendations in relation to care planning. We were concerned there was little evidence of meaningful engagement with individuals, and this was reflected in their electronic records as we could not consistently locate goals, interventions and reviews to determine whether the individuals were reaching their optimum level of recovery.

To ensure participation and supported decision making, evidence as to how efforts had been made to do this, and the actions which are part of the care plan, are clear and goals are attainable. We were keen to review care plans and individual's care records which continued to be held electronically on TRAKCare.

Where we found some progress in relation to care planning, this was not consistent. We were able to locate care plans that identified specific identified needs and interventions, regular reviews to determine progress. Unfortunately, of the care records and care plans we reviewed this progress was limited and inconsistent.

We saw care plans that lacked evidence of participation with individuals. We could not find where goals had been agreed and how reviews would evidence progress. We became aware of an individual whose admission had been lengthy and who was without a specific care plan that reflected their mental health needs to promote recovery. We brought this to the attention of senior nursing staff on the day of the visit as this was a considerable concern.

During our reviews of care plans, we cross referenced those with assessments, including ones specifically related to risk. We could not find evidence of a direct correlation between assessments and care planning, particularly for individuals who were admitted to hospital due to increasing concerns for their safety.

However, where we were able to locate care plans that would be consider person-centred, those were comprehensive, strengths-based with a clear focus upon recovery in terms of a subjective view from individuals admitted to Meadows Ward.

Recommendation 1:
Managers must ensure that individuals are fully involved in each stage of their recovery and that 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 should carry out an audit of care plans to ensure all individuals admitted to Meadows Ward are provided with documented evidence of how care is to be delivered and by whom.

When meeting with individuals on the day of the visit, we asked whether they were aware of discharge planning. Most individuals did not feel they were part of this conversation with the ward-based team and not been provided with information or guidance, for example, receiving a likely discharge date and limited details as to who would support them, post discharge from hospital. When we reviewed individuals' care records, we typically could not see evidence of discharge planning either in specific discharge care plans or MDT meeting records. We brought this to the attention of the senior leadership team as we appreciate successful and sustainable discharges from hospital-based care require a robust approach that is consistent, person-centred and should include relatives and carers, where relevant.

Recommendation 3:
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. `

Care records
Information on individual's care and treatment was held electronically on TRAKCare; we found this electronic record system easy to navigate.

We were pleased to find that all staff input information onto TRAKCare, this included nursing, medical and AHP staff. Daily continuation notes were captured using a 'canned text' framework that provided several areas of focus such as mental health and well-being, activities, daily risk assessment and medication.

Where we saw evidence of one-to-one interactions between individuals and staff there was a richness of detailed narrative. There was both a subjective and objective view and this allowed the reader to appreciate how each individual's mental health and well-being was at the time of the meeting. Of the care records we reviewed, there were several that appeared meaningful and where we could see that there had been an opportunity for individuals to explore what was important to them in relation to their recovery. We were told during our own conversations with the individuals that we met with that they were often the initiators for one-to-one meetings with staff. This was often when they had felt particularly anxious and required staff to support them.

We were told those meetings were helpful however, having regular scheduled one-to-ones would be equally beneficial rather than specifically during times of heightened stress and distress. We were able to see evidence of staff having considered a

strengths-based approach when working with and supporting individuals. The interactions were informative, and we could see where assessments correlated with care plans.

During the review of care records from our last visit we saw repeated use of generic language for example “evident on the ward” and “keeping a low profile”. We were disappointed to have found this once again, and due to this, have repeated the recommendation that we made in 2024.

Recommendation 4:
Managers should ensure members of the ward-based team record personalised, strengths-based, meaningful information in individual’s daily continuation notes.

The limitations of the accounts of each individual’s presentation did not provide evidence of person-centred, therapeutic engagement. From the action plan provided by the service, we could see documentation in care records was going to be an area of focus in terms of learning and development. Unfortunately, we could see there were some staff who had invested in ensuring daily recordings provided a detailed narrative, this was not consistent.

We were pleased to see physical health and well-being continued to be an important area of focus on Meadows Ward. Where there were identified needs for individuals, this was addressed by medical staff and the advanced nurse practitioner (ANP) and followed up where appropriate.

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)
Care and treatment was provided by a MDT including consultant psychiatrists, speciality doctors, nursing staff, and OT. Referral to AHPs, including speech and language therapy, physiotherapy and dietetics was also available for individuals admitted to the ward.

Other disciplines that provided input to Meadows Ward included psychology and arts psychotherapy. We were told by the ward-based team that psychology and arts psychotherapy had continued to have a recognisable positive impact upon each individual’s care and treatment.

In our review of care records, we saw detailed and comprehensive outcomes from one-to-one sessions between psychology and individuals. We could see this had extended to the work undertaken by the ward’s arts psychotherapist. Having input from both professionals had provided opportunities for individuals to consider a psychological model of care and treatment and the potential to enhance the ward-

base team's response to working with individuals, who by virtue of their early life experiences, could present with heightened stress and distress.

Each consultant psychiatrist held a weekly MDT meeting. In attendance at those meetings were medical staff, nursing staff and on occasion, AHPs including psychology and arts psychotherapy. We reviewed MDT meeting minutes which were held electronically on a 'mental health structured ward round' template.

The template had specific areas of focus to consider, such as mental health and physical well-being, medication management and concordance, authorising treatment in relation to the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) and updates from AHPs. There was also a record of the discussion in relation to discharge planning and identified goals needed to enable a date for discharge to be agreed.

While we could identify professionals who had attended the weekly meetings, the absence of individuals and their relatives was noted. We could see where consultants had reviewed individuals prior to the meeting and where feedback had been communicated, in terms of decisions, to individuals by medical staff post MDT meeting. However, for some individuals, this way of providing feedback had left them feeling decisions were made for them rather than with them, which would have been their preference. We would suggest a review of the current approach; the Commission considers that offering individuals the opportunity to attend their MDT would promote the principle of participation and support individuals in Meadows Ward to contribute as fully as possible with their care and treatment.

We were aware as part of the weekly MDT meeting that discharge planning was part of the structured template. We had difficulty finding a consistent approach to planning individual's discharge. There were identified dates however, there was an absence of community services i.e. social work and community mental health services. While we accept competing demands for services may mean attendance at regular weekly meetings may not always be possible, having evidence of which services were currently involved, or would be, to support a successful discharge would have been beneficial.

Use of mental health and incapacity legislation

On the day of the visit, 13 individuals in the ward were detained under the Mental Health Act. All documentation relating to the Mental Health Act and the Adults with Incapacity (Scotland) Act, 2000 (AWI Act) were electronically stored on TRAKCare and easily located.

Most of the individuals we met with had a good understanding of their detained status under the Mental Health Act and their rights regarding this. However, there were several individuals who were not able to tell us whether they were receiving

their care in hospital informally or as a detained person. We would have expected all individuals who are subject to Mental Health Act legislation to have a specific care plan that offered support in terms of understanding this legislation and restrictions placed upon them.

We would also have liked to have seen evidence of how the ward-based team and their local authority colleagues ensured individuals had a good understanding of Mental Health Act and/or AWI Act legislation. Where there were gaps in understanding that had been identified, how support was provided and by whom needed to be documented. Of the files we reviewed, there was evidence of legal and advocacy involvement; we were told referrals to advocacy were accepted quickly and their attendance was valued.

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 of consenting 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 medication prescribed beyond two months, when the individual does not consent to the treatment or is incapable of doing so. In these instances, treatment must be authorised by an appropriate T3 certificate or a T2 certificate if the individual is consenting.

We reviewed the prescribing of medications and treatments for all individuals as well as the authorising of treatment for those subject to the Mental Health Act. Medication was recorded on the HEPMA (hospital electronic prescribing and medication administration) system. T2 and T3 certificates authorising treatment were stored separately on TRAKCare.

We have previously advised that navigating both electronic systems simultaneously can be a practical challenge for staff. We had previously suggested a paper copy of all T2 and T3 certificates be kept in the ward dispensary so that nursing and medical staff have easy access and opportunity to review all T2 and T3 certificates. During our review we were given paper copies of T2 and T3 certificates however, all were of individuals who had either been discharged from hospital or transferred to other wards. We could not locate current certificates for the individuals who required them. Once again, we proposed this situation was potentially problematic as it could reduce the ease of checking for the correct legal authority for prescribed treatments.

On the day of the visit, we found that an individual had been prescribed psychotropic treatment for over six months without the required legal authority in place. We brought this to the attention of the senior leadership team and the individual's responsible medical officer (RMO). We would expect in this instance the RMO would notify the individual in writing, to advise them of this error and of their legal rights

under the Mental Health Act. In our visit in April 2024, we made a recommendation about lawful treatment and have repeated this again.

Recommendation 5:
Managers and responsible medical officers must ensure that all consent and authority to treat certificates are valid, and that all psychotropic medication is legally authorised, and audit processes are introduced to ensure compliance with this.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a named person had been nominated, 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 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 found section 47 certificates and treatment plans had been completed and stored on TRAKCare.

Rights and restrictions

Meadows Ward continued to operate a locked door, commensurate with the level of risk identified with the individual group. Unfortunately, with this recent visit we could not locate a locked door policy which would usually have been displayed at the entrance of the ward. We asked the ward's leadership team to ensure the locked door policy was clearly displayed for individuals and any visitors to the ward.

We were pleased to have found all individuals admitted to the ward had an up-to-date pass plan in place and that it was accessible in their electronic records. Not all individuals we met with had a good understanding of their detention status; we proposed a system to be put in place for staff to re-visit rights and restrictions for all individuals. This would help to identify any gaps in their understanding and for staff to provide accessible information to support individuals and their relatives as required.

Recommendation 6:
Managers should ensure staff provide information to individuals and their carers in relation to their rights. Where there may be gaps in understanding those are addressed through accessible and meaningful material.

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 a person is a specified person in relation to this and where restrictions are introduced, it is

important that the principle of least restriction is applied. On this visit, there was nobody in Meadows Ward who was subject to sections 281 to 286.

When we are reviewing each individual's 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 were aware not all individuals subject to the Mental Health Act had an advance statement in place however, we were able to locate completed statements held in TRAKCare.

During our meetings with individuals, they told us that there had been instances where they had witnessed aggression towards nursing staff and between people on the ward. We were informed that some people had felt 'targeted' by their peers and had at times felt their safety and security had been compromised.

We appreciated their candour, as highlighting safeguarding concerns in a ward environment can at times be difficult to define. We raised this with the leadership team during our end of day meeting and enquired whether safeguarding legislation, for example, Adult Support and Protection (Scotland) Act, 2007 (ASP Act) had been considered for people who had experienced potential harm during their admission to Meadows Ward. We were informed safeguarding legislation was not routinely considered where there had been instances of aggression either between peers or towards staff. We were told all staff completed a mandatory 'e-learning' module which provided a general overview of the legal framework.

The leadership team acknowledged all staff would benefit from attending specific training delivered in-person to enable staff to support and protect adults from potential harm.

Recommendation 7:
Managers should ensure all staff have the opportunity to attend Adult Support and Protection (Scotland) Act 2007 training. Where there is consideration for the use of ASP Act legislation, managers should ensure all staff have competencies and confidence to raise safeguarding concerns through the local authority ASP Act services.

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.

Activity and occupation

We heard OT was highly valued and had a role that included functional assessments, therapeutic engagement and providing links to community services.

We saw detailed assessments and associated care plans completed by OTs. We heard from individuals how they felt regular input had provided an enhanced opportunity to learn new daily life skills and maintain existing abilities and that this would be helpful post-discharge.

We also heard how arts psychotherapy had provided individuals with opportunities to consider a therapeutic process to address symptoms of emotional distress. Sessions undertaken by arts psychotherapist and psychology were documented and held in TRAKCare, and outcomes were shared with the MDT as part of an overall model that included recreational and therapeutic engagement.

We were pleased to hear the post of recreational assistant had been recruited to. This post was highly valued as there was a recognition that individuals benefitted from either one-to-one activity sessions or in supported group work with peers. We were told there were current challenges to having regular structured programme of activities based on the ward, as the ward had limited space to accommodate activities due to rooms that had been designated for activities being regularly used as 'surge' bedrooms.

For this reason, we were told most activities were based away from the ward in other areas across the hospital site. While this was an opportunity for some individuals to have time away from the ward and meet people from other wards, this was not an accessible situation for everyone for reasons of safety or confidence leaving the ward environment. While there was not a structured programme of activities available for individuals admitted to Meadows Ward, we were told there was a day service run by Scottish Action for Mental Health (SAMH) that offered a range of activities and groups based in the HIVE, which is situated in the hospital grounds. There were also opportunities for individuals to attend the hospital-based gym to promote health and well-being.

During our meetings with individuals there were themes that included a sense of boredom and that having a programme of activities that was available for everyone would have been welcomed. We made this recommendation after our previous visit and have again repeated it for this visit.

Recommendation 8:
Managers should consider addressing the availability of dedicated space in the ward while seeking clarity whether a structured programme of accessible ward-based activities would be routinely available for everyone.

The physical environment

We were pleased to see during our visit to Meadows Ward there had been some updating and redecoration of the communal areas.

On entering the ward, it appeared more welcoming after being refreshed. During our walk around the ward environment, we became aware there was minimal artwork or identified spaces for individuals to use either for relaxation or socialising. Space that had been available as a reading nook had its furniture removed after an incident and this included access to books and reading material.

The ward-based team were not certain this reading and relaxion space would be reinstated. A room that had been specifically designed to be used as a quiet space to either watch TV or undertake activities had been used as a 'surge' bedroom. The room was deemed unsafe to use as a bedroom as it had not met the safety standards in relation to ligature risks. Nevertheless, the room still had a bed in it, and no door as it had become faulty and unsafe. The space could not be used for activities purposes due having a bed in situ and no door to offer privacy.

We asked the leadership team why a bed had remained in the room considering current unavailability of recreational space and whether the door would be replaced. We were informed the bed would be removed; however, the door would not be replaced for several weeks due to the manufacturer's processing time.

In our previous report, we raised our concerns about a contingency or surge bed being placed in an interview room. On the day of this visit, we noted the interview rooms were still accommodating continency beds. One interview room was not in use but still had a bed in the room. The other interview room was in use as a contingency bedroom. We viewed this room and met with the individual currently accommodated in the room. We were told the lack of washing and toileting facilities was an issue and noted that all other bedrooms had en-suite facilities. To access washing facilities the individual had to ask a member of staff to open the door to the communal bathroom which had a bath but no shower. We were told this was not ideal and had been their experience for several weeks.

Again, we discussed this ongoing issue with the senior leadership team on the day of the visit. They agreed this ongoing situation was far from ideal and did not offer privacy or dignity for people admitted to that room. We were informed there had been another ward that accommodated older adults previously that has been re-opened in an attempt to alleviate ongoing capacity issues across the general adult admission wards. We were advised that a new purpose-built community facility would be opening to support discharges from hospital-based care, back into the community. We were not given specific timescales for the opening of the new facility therefore it was likely the use of contingency beds in interview rooms and the divert protocol would remain in place.

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

In our previous visit reports to Meadows Ward, we had highlighted the non-compliance with the Scottish Government's NHS no smoking legislation. This resulted in a recommendation that this was explained and complied with by all individuals and staff. We received a response from the service detailing their plan to ensure compliance with this legislation, including the provision of education, advice, smoking cessation interventions and signage. We were also told there would be a booklet available for all individuals admitted to the hospital to advise them the Royal Edinburgh Hospital is a smoke free hospital.

On the day of this visit, we wanted to follow up on the previous recommendation however, despite the information provided in the action plan supplied by the service, we were both concerned and disappointed to find that there continued to be little progress in implementing the smoke free legislation. We noted that individuals continued to smoke in the ward's courtyard which was accessed from the ward's communal sitting and dining room. We visited the courtyard and saw the ground was littered with cigarette ends leaving the outdoor space appearing unkempt and uninviting for people to use. We also witnessed individuals openly 'vaping' in their bedrooms and in communal areas of the ward.

We have again repeated our recommendation of April 2024.

Recommendation 10:
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.

Any other comments

We were pleased to find access to psychology and arts psychotherapy had become embedded into Meadows Ward. We were told by people we met with they had found a psychotherapeutic and psychological approach to understanding their unique difficulties had been extremely beneficial in their recovery from mental ill-health.

Summary of recommendations

Recommendation 1:
Managers must ensure that individuals are fully involved in each stage of their recovery and that 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 should carry out an audit of care plans to ensure all individuals admitted to Meadows Ward are provided with documented evidence of how care is to be delivered and by whom.

Recommendation 3:
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 4:
Managers should ensure members of the ward-based team record personalised, strengths based meaningful information in individual's daily continuation notes.

Recommendation 5:
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Recommendation 6:
Managers should ensure staff provide information to individuals and their carers in relation to their rights. Where there may be gaps in understanding those are addressed through accessible and meaningful material.

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Recommendation 8:
Managers should consider addressing the availability of dedicated space in the ward while seeking clarity whether a structured programme of accessible ward-based activities would be routinely available for everyone.

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Service response to recommendations

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

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

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

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

The Commission visits people in a variety of settings.

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

When we visit:

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

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

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

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

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

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

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

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

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

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