Mental Welfare Commission for Scotland

Report on unannounced visit to:
Wards 2 and 3, Forth Valley Royal Hospital, Stirling Road, Larbert, FK5 4WR

Date of visit: 5 June 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

Wards 2 and 3 provide inpatient assessment and treatment for adults experiencing acute mental ill health from across the Forth Valley area. Ward 2 provides care and treatment for those predominantly from Stirling and Clackmannanshire and Ward 3, the Falkirk area, but this can be flexible when needed.

Additionally, the wards co-facilitate electroconvulsive therapy (ECT) and provide detoxification treatment for those with problems with substances. Wards 2 and 3 are located in the mental health unit of Forth Valley Royal Hospital and have 20 and 21 beds respectively.

We last visited this service on separate announced ward visits on 23 April 2024 and 30 April 2024. On this occasion we undertook an unannounced visit to both wards to follow up on the previous recommendations that were made. On the day of our visit, there were 19 individuals in each ward.

We had previously made recommendations about specified person legislation and a further recommendation about observance to the no smoking policy. We heard from the service that a short life working group was tasked to look at training and development needs relating to current legislation, and incorporated information on specified person legislation into other training. An audit of the documentation was designed and implemented and specified person flowcharts were displayed in both wards. Additionally, a small number of staff were able to attend the Commission's webinar 'rights to consider when applying restrictions' in September 2024. More staff will access this when available on the Commission website.

We were pleased to see that the mental health unit was now successfully supporting individuals to observe legislation about not smoking in hospitals. There was evidence of a strong multidisciplinary approach to support implementation and continued compliance with the law. We were told about collaboration with individuals in meetings and about additional activities introduced in the garden area to discourage the former use and association with smoking.

Other recommendations specifically for Ward 2 were for care planning, and therapeutic activity. Action plans received from the service detailed improvements to be made to achieve more person-centred care planning that evidenced participation. This included creating an exemplar using the Commission's good practice guidance.

Recording of therapeutic activity was moved from the general contact section of the electronic notes to ensure it was more easily identified including which type of activity was undertaken. Therapeutic benefits of activity participation would also be reviewed in multidisciplinary (MDT) meetings.

Who we met with

We met seven individuals from Ward 2 and three from Ward 3. We reviewed the electronic care records of ten people in total, some of those we had met in person. Due to the unannounced nature of this visit, there were no relatives or carers available to meet with us on the day, but we had previously received some feedback from relatives via our telephone advice line.

We spoke with the clinical nurse manager (CNM), the senior charge nurse (SCN) from Ward 2 (the other SCN was on leave), an activity co-ordinator, third year nursing students, the physiotherapist, pharmacist and pharmacy technician and one of the consultant psychiatrists. We also met the service manager (SM) during the feedback meeting at the end of the visit.

Commission visitors

Denise McLellan, nursing officer

Lesley Paterson, senior manager (practitioners)

Tracey Ferguson, social work officer

Kathleen Liddell, social work officer

Susan Hynes, nursing officer

What people told us and what we found

Ward 2

Overall, the feedback received from people in Ward 2 was positive and most individuals told us that they were treated well. We heard that they met with their consultant psychiatrist regularly, had positive supportive relationships with nursing staff and other professionals involved in their care and treatment and were aware of their rights.

One person told us that they had not been offered any one-to-one meetings with nursing staff. They described the environment as being noisy at times and not having access to an ensuite bathroom meant they had to access a communal shower that was not close to their bedroom. They found this a problem given the ward could be noisy and overwhelming for them and did not cater for their sensory needs. They described all staff as “friendly and nice”.

Managers were aware of the concerns in relation to noise levels and told us this was being explored. Consideration was being given to solutions such as acoustic panels to dampen noise given the impact this could have on levels of stress and distress and the general ambience of the ward.

Another person told us that overall staff were “pretty good.” They were pleased to have been given a room with en-suite facilities, and they also found the standard of food to be good. They acknowledged the variety of activities provided but had chosen not to participate due to their preference to use time away from the ward.

We met one individual who had been admitted on an informal basis. They said they felt safe and were content to remain, but they had a lack of understanding around their rights, saying they had been told they could not spend any time way from the ward.

We had been made aware of correspondence between an advocacy worker and our engagement and participation officer in relation to a relative (who was also a nominated named person) experiencing difficulty obtaining information concerning an incident that had occurred on the ward. When this was highlighted, it became apparent that there had been miscommunication and the team looked to resolve this by speaking with this relative and ensuring that they were invited to meetings as requested.

Someone else spoke of being given information about appealing their detention, about support being received to contribute to their care plan and that a referral had been made to specialist services for their physical health. They had not received a copy of the plan but confirmed that there had been regular reviews, some as regular as weekly at one point. They felt it may be a good idea to have their own copy and planned to request this. Overall, they described nursing staff as supportive but often

very busy, which meant at times they felt they had to “chase them up”. We that that although the ward could be “frightening” at times, generally it was “comfortable apart from the underfloor heating” as this made the ward “clammy” due to the ward windows being locked.

Ward 3

We received feedback from one family prior to our visit, and they spoke of a lack of family involvement and participation. They also raised concerns about communication, environmental issues, ward culture and the attitude of some of the nursing staff was described as “rude”. They were also unhappy with a lack of meaningful activity for their relative.

Despite attending MDT meetings, one person said they did not feel involved in any decision making around their care and treatment. They felt decisions had already been made, therefore attending meetings was “tokenistic.” They spoke of a lack of participation in their care plans and despite having been allocated a key nurse, they had not had any one-to-one interactions to discuss their views on treatment. The view offered was that they felt most nursing staff did not have a positive attitude, they “can’t be bothered” with those in the ward and that anything they ask for is “too much of a bother”. They added that nursing staff spent a lot of time in the office and “there is no therapeutic interventions.” They said activities were offered however, felt they were too generic, and they found the environment to be difficult at times due to noise levels. The food was described as “okay, but very repetitive.”

A different individual expressed similar views about lack of availability of nursing staff due to them being in the office “most of the time”. They were happy that they had regular access to the gym located in the unit.

Another person we met told us that overall, they had found this admission useful and that they attended meetings regularly and their views were listened to, as it was important to be involved in decisions about care and treatment. They said that although there were activities offered, they were of no interest to them. This person also indicated that negative staff attitudes contributed to a “hostility on the ward - them against us”. They commented there was increased interaction between staff and individuals that day due to Commission visit but that staff usually spent a lot of time in the office. Assurances were given that concerns reported during our feedback would be explored further by managers.

One other person told us that they had been given “a nice welcome” when they were admitted.

We heard from nursing staff in both wards that clinical supervision was supposed to be provided monthly but due to staffing constraints this was not happening with this

frequency. Reflective practice was ongoing jointly for the wards due to this being facilitated by community staff to the wards.

We were able to speak with three student nurses on placement in Ward 2 and 3 who offered feedback about the learning opportunities available. They told us that they helped with admissions, medication administration, recording physical observations and attended MDT meetings. One highlighted that sometimes learning opportunities felt reduced due to the number on placement at any one time and that they had raised this issue with the course programming team.

Care, treatment, support, and participation

Individuals were invited to attend weekly review meetings, and we saw that there was some contact with families and carers. We found evidence of advocacy involvement and consultation with named persons. Weekly community meetings were ongoing across both wards to promote participation and further explore activity provision so that this was regular and meaningful. Physical health monitoring was good with regular reviewing and advice, and support was offered to manage physical health concerns. Referrals to specialist services were made where required.

The SCN from Ward 2 advised that nursing staff levels had been at an amber level for 80% during the last six-month period. Seasonal sickness absence, changing roles, and posts, combined with a reduction in the use of bank staff were some of the reasons given to account for the shortfall. Where acuity had fluctuated, redeployment and some bank allocation continued to be necessary. The wards were not at full nursing complement, but it was expected that this would be remedied by staff moves following the closure of Russell Park at the nearby Bellsdyke Hospital in the coming months. We were also told that planning and reorganisation on the days when meetings occurred in Ward 3 had helped to free up more nursing time.

A quality improvement initiative to increase the scope of physiotherapy provision to the wards had led to groups such as street soccer, tai chi in the gym, boxing and dance classes being developed in response to outcomes from ward community meetings with a focus on reducing stress, anxiety, improving mood and reducing anger. There had been a 90% uptake in the initial eight-week pilot commenced in November 2024. We heard that this more focussed provision to the admission wards encouraged opportunity for engaging those experiencing poor physical health comorbidly with mental health problems. Monthly themes included educating people on, for example, respiratory physiotherapy for those with conditions such as such as chronic obstructive pulmonary disease (COPD). Referrals were informal and could be made verbally, by email or at ward handovers. 15 people were on the caseload across the adult mental health unit which included Ward 1, the intensive psychiatric care ward (IPCU). This correlated with a reduction in referrals for physical activity, falls, chronic back pain, strengthening exercises and foot pain.

Morning exercise in the ward gardens was introduced as an intervention to support the no smoking policy. This activity was cofacilitated by occupational therapy (OT) and incorporated into the weekly activity planner for both wards.

Care records
Individual care records were documented in the electronic information management system 'Care Partner' in place across NHS Forth Valley. This system was used by all professionals involved in care and treatment delivery and we found it relatively easy to navigate.

Ward 2
The care plans in Ward 2 covered a range of physical and mental health needs, but we found many were written in a way that appeared to be directed at the individual as opposed to being written collaboratively. They appeared to be based on a generic template and therefore lacked personalisation. In one continuous intervention recovery care plan there was evidence of person-centred approaches for support during periods of stressed and distressed behaviours with detailed de-escalation skills used, however, information such as staff signatures and dates were not consistently recorded.

We found a care plan for an individual who had been admitted on an informal basis that documented this status and included psychological approaches and use of medication as treatment options. It was recorded in the plan that should they refuse medication it could be administered via an intramuscular route which may involve restraint. Without the necessary legal authorisation, the Commission would not be consider this to be good practice and in keeping with the individual's rights.

For one individual whom English was not their first language, staff were communicating via the Google Translate application on a day-to-day basis. Care plans documented the need for translation services for meetings and legal information, but we found no evidence that the care plan itself had been translated and shared with the individual, therefore we felt this lacked participation; we requested that key documentation be translated.

We also noted a lack of care plans for one individual who had been admitted during the previous week and no specific plan for another receiving ECT. This was highlighted to the SCN.

While we were pleased to find that there were frequent one-to-one interactions, we found the level of detail recorded in the notes that evidenced participation and the individuals' views was variable. For some, there was regular and detailed entries describing who initiated one-to-one's, but other entries were limited to nutrition, sleep and medication, with minimal detail about the person, their clinical presentation or their day.

Ward 3

Care plans in Ward 3 were of mixed quality with some being more detailed than others. These included medication, legal status, physical health, mental state assessment, activity, and time off the ward plans. Each had sections for goals and interventions, but information recorded in agreed goals was limited and did not capture individuals' views.

Interventions were more robust in relation to who was responsible for delivering the care and treatment but lacked evidence of participation. Information was generic and not person-centred. One care plan failed to accurately reflect an individual's views about medication despite this being known and documented comprehensively in the MDT meeting records. The care plans were reviewed regularly but we did not find summaries of whether interventions were effective or required change. We also found that some of the language used in the continuation notes was generic and not always strengths-based. Entries including 'brittle' and 'visible around the ward' did not provide the context to interactions with others, or indicate how this person had spent their day. We noted the use of the word 'confinement' in one entry and would suggest a more therapeutic response be documented. There was also a lack of one-to-one interactions recorded in the notes.

Recommendation 1:

Managers should ensure that all care plans across the service are individualised, person-centred, and detail interventions which support individuals' movement towards their care goals. These should evidence individual and carer involvement, be regularly reviewed and the quality of the care plans should be audited.

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.

There was evidence of ongoing physical health monitoring, interventions, advice and support offered to manage concerns across both wards. This was supplemented by increased involvement from physiotherapy who were able to offer provision to the MDT and education to individuals who may have lacked opportunity to engage in the community. Morning exercise in the gardens had commenced, and details were recorded in the allied health professional (AHP) notes on Care Partner.

OT continued to work with individuals assessing their functional skills. Activity provision was documented in detail including the level of engagement and associated therapeutic benefits.

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

Risk assessments documentation using the functional analysis of care environments (FACE) tool was of mixed quality. We saw some being completed comprehensively although we viewed one in Ward 3 that lacked detail on the summary of risk or protective factors and the information was written mainly as bullet points. The risk management interventions also lacked detail.

A risk assessment in Ward 2 had not been updated since an episode of deliberate self-harm (DSH) four days previously. We were told by managers that the MDT discussed risk at each MDT meeting but were currently reviewing risk assessments and that this was a large project where they were seeking wider agreement to take a more narrative approach to documenting risks. The service had a meeting regarding this planned for later in the day.

Multidisciplinary team (MDT)
A broad range of professionals including consultant psychiatry, nursing staff, psychology, OT, activity co-ordinators, social work (SW), physiotherapy and pharmacy had representation in the team. Referrals could be made to other disciplines, including dietetics and speech and language therapy, as needed. Daily huddle meetings provided an opportunity for all SCNs and the junior doctor to coordinate what needed to be planned with the day's reviews and any new admissions.

The MDT meeting template used in both wards evidenced weekly meetings and attendees. Physiotherapy and OT attended alternate meetings and SW attend where their input was required. The nursing report providing an overview of the previous week, including individuals' views, which were populated in the document prior to the meeting. The completed MDT record provided a comprehensive summary of discussion, including progress and discharge planning that involved referrals being made to other services, as well as details of suspension of detention and care programme approach (CPA) involvement where indicated. Key outcomes and who was responsible for progressing the agreed actions were clear.

We saw from records across both wards that individuals had input from various members of the MDT and there were regular medical reviews. There was evidence of MDT collaboration with activities that had been scheduled to alleviate specific symptoms of illness for individuals. Views of individuals and relatives were gathered prior to meetings so they could be considered. Individuals were able to attend meetings if they wished and we saw involvement from independent advocacy services and on occasion, some families attended meetings.

Use of mental health and incapacity legislation

Part 16 of Mental Health (Care and Treatment) (Scotland) Act, 2003 (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. On the day of the visit, there were 13 people in Ward 2 and 12 in Ward 3 who were detained under the Mental Health Act, with the relevant documentation easily accessible on Care Partner.

In Ward 2, consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were available and we saw evidence of discussion about electroconvulsive therapy (ECT) and a review of an individual's capacity documented in the records along with their signed consent. We saw that one individual had been prescribed a medication not authorised on the corresponding certificate, and another where the clinical team was unaware that a valid certificate authorising treatment was already in place.

In Ward 3, we found that one person had been given medication for a period of five weeks which was not authorised on their current T3 certificate. We saw that a T4 notification to record the giving of urgent treatment had recently been completed and a second opinion requested to rectify this issue. Two other people were close to receiving treatment for the two-month period and would require either to give their consent to further treatment or be given it in accordance with Part 16 if authorised by a second opinion doctor. There was no T2 certificates stored in their records and if T3 certificates were required, there was insufficient time to arrange second opinion reviews. We were concerned about the robustness of the system currently in use to audit this.

We were told that pharmacy audited Part 16 medication on a quarterly basis and the pharmacist endeavoured to attend the weekly MDT meeting. This was not always possible due to some staffing issues and providing cover for the rehabilitation wards at Bellsdyke Hospital as well as providing advice to the community mental health team (CMHT). Where more urgent action was needed this could be highlighted by the pharmacy technician out with the meeting.

We advise that a more frequent audit process is needed as without it, there is the potential for an increase in the risk of further discrepancies where medication is being given out with legal authority.

Recommendation 2:
Managers must ensure that all psychotropic medication is legally authorised and should identify a robust system of auditing this across both wards to ensure that all treatment given to detained individuals is authorised in accordance with conditions set out in the Mental Health Act.

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 named person had been nominated, we found the appropriate information relating to this.

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. Documentation relating to the AWI Act, including certificates around capacity to consent to treatment was available in both wards.

Rights and restrictions

The wards operated an open-door policy for those not subject to legislation. A reception facility immediately at the entrance to both wards provided an area of additional security for checking the agreed time off ward, as well as monitoring people on their return for safety. It was managed on a rotational basis by staff from both wards who were cognisant of potential risks.

When speaking to individuals and reviewing records it was clear that although some people were unhappy about being detained, they had an awareness of the legislation used and their rights. They knew how to appeal their detention and had active involvement with the local Forth Valley independent advocacy service. On our last visit to the wards, we became aware of a misunderstanding that advocacy was only available for those formally detained under the Mental Health Act and generally for the purpose of appealing their detention. We were pleased to see an increased awareness that advocacy is available to anyone receiving mental health treatment in Scotland.

One person admitted to Ward 2 was less clear of their rights and their informal status. We were unable to find any promotion or explanation of rights for those admitted on a voluntary basis.

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. No individuals were subject to any additional restrictions in either ward on the day of our visit.

When we are reviewing case records 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 these. The Mental Health act requires that when advance statements are overridden, the reasons for doing so are given, in writing, to the individual and their named person and that the Mental Welfare Commission for Scotland is also informed. We saw some advance statements on Care Partner. We were aware that individuals were given the option to ‘opt-in’ to make an advance

statement on admission to the ward. During admission process individuals are asked about making an advanced statement. At the time, people can 'opt in' to agree to complete at the time. We could not find what follow up action was taken if a person did not want to complete an advance statement or were too unwell at the time. We suggest that the 'opt in' is revisited later on in the individual's the admission.

We acknowledge that it can be difficult for individuals to write advance statements when acutely unwell but felt greater promotion was needed including further discussion throughout the admission as their mental health improves. This may increase participation and understanding about their treatment.

Recommendation 3:
Managers should ensure that staff are trained to support the promotion and recording of advance statements for individuals who wish to complete one.

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

On our previous visit we noted improvements to the frequency and variety of activity offered. We were pleased to see people engaging in activity during our visit and others were enjoying time out of the ward.

Activity continued to be arranged linked to the outcomes of weekly community meetings. This collaboration resulted in a broad range of indoor and outdoor occupation. One of the co-ordinators we met told us that in addition to the full ward timetable being displayed in communal areas, individuals were given their own personalised copy. Additionally, consultant psychiatrists were informed in order to minimise disruption to activity where this could be avoided. Unfortunately, we heard from some individuals that staff absence could have a negative impact on what was being delivered, despite efforts being made to provide this.

We were given a copy of the planner and saw a variety of activity available including a newly created breakfast group which had been in response to the smoke cessation initiative. The physiotherapist and student nurses provided morning exercise sessions in the garden areas, as well as dance fitness classes and boxing. Activity co-ordinators facilitated woodland walks, gardening and hydration groups, arts and crafts, movie afternoons, gym sessions, street soccer and table tennis. We were able to observe part of the music and movement group which was well attended and clearly enjoyable for those participating. Exercise could be adapted to cater for

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

individuals' differing levels of mobility, balance and fitness levels. Anxiety management and decider skills were available, in addition to relaxation and self-care and smoking cessation drop-in sessions.

NHS Forth Valley funded an external instructor to deliver ward based visual art sessions. We met the development officer from 'Art Link Central' who was leading the activity for three individuals that morning, and they told us that each eight-week block could accommodate up to eight individuals per session and people could be signposted to community groups to continue this therapeutic activity after discharge.

The physical environment

The layout of both wards consisted of single bedrooms, some which had ensuite facilities. Communal areas in both wards were well used, and the standard of cleanliness had been maintained by housekeeping staff. There continued to be an emphasis to ensure communal areas were bright and welcoming with an array of artwork and information displayed in rooms and corridors.

Bedrooms were personalised with photographs and art from groups individuals attended. The bedrooms were a good size with ample storage for personal effects appropriate to the setting. We did however hear from individuals and staff about how uncomfortable the environment was due to the windows being locked and air conditioning not working. This was discussed with managers who told us that windows were required to be locked due to the ligature risk they posed. Anti ligature work had been agreed, and this additional issue had been added to other essential modifications scheduled over the longer term. This programme of works was due to commence later in the year and temporary solutions such as film on windows to reflect heat was being sourced. Managers were also consulting with infection control colleagues regarding ventilation.

On our last visit we noted the smell of cigarette smoke in some areas of Ward 3 and observed litter and cigarette ends in Ward 2's garden. We were told by some people of their reluctance to use the garden because of its use by smokers. We were pleased to find neither issue arose during this visit with both garden areas being easily accessible, well maintained and providing a relaxing and pleasant space for everyone.

The wards were located next to each other and shared access to the gym, the OT kitchen and dining room. Mental health pharmacy was located in the shared corridor which the team told us was helpful.

Any other comments

We acknowledged the progress made in achieving the smoking ban to bring it in line with smoke-free perimeter legislation brought into effect in 2022. It was particularly

positive to see evidence of how a whole team approach had enabled this change to be managed effectively and with a focus on health promotion. Sanctioned by the legislation and following consultation with other health board areas, it was showing some initial success. Although effective for one week, staff were cognisant of challenges but remained confident about how they would manage. Some individuals we spoke to had remarked about being pleased about this change and we were told that there had already been benefits, such as a decrease in people's carbon monoxide readings. Advice, support and other resources were available from 'Quit Your Way Scotland'.

We noted there had been a focus on increasing knowledge and training across the service and the Alloa social work team was delivering ongoing sessions to increase knowledge of the Mental Health Act, the AWI Act and the Adult Support and Protection (Scotland) Act 2007. The learning platform TURAS was available for further training including incapacity and adult support and protection. Staff meetings were minuted and made available for any staff not able to attend. There was also the addition of a 'shout out' board which included feedback for individuals to foster support, recognition and encouragement to staff who were working in challenging situations. We were aware that there had been several changes in personnel and that both wards had relatively new teams and would need a settling in period.

Summary of recommendations

Recommendation 1:
Managers should ensure that all care plans across the service are individualised, person-centred, and detail interventions which support individuals' movement towards their care goals. These should evidence individual and carer involvement, be regularly reviewed and the quality of the care plans should be audited.

Recommendation 2:
Managers must ensure that all psychotropic medication is legally authorised and should identify a robust system of auditing this across both wards to ensure that all treatment given to detained individuals is authorised in accordance with conditions set out in the Mental Health Act.

Recommendation 3:
Managers should ensure that staff are trained to support the promotion and recording of advance statements for individuals who wish to complete one.

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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