Mental Welfare Commission for Scotland

Report on announced visit to: Queen Margaret Hospital, Ward 3 and 4, Whitefield Road, Dunfermline, KY12 0SU

Date of visit: 16 and 17 February 2026

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

Ward 3 is an 18-bedded, mixed-sex admission ward and provides assessment and treatment for older adults who have a diagnosis of dementia, including organic-related illnesses. The ward also admits individuals with functional illness, including depression and psychosis; on the day of the visit there were 15 individuals in the ward

Ward 4 is an 18-bedded, mixed-sex ward for older adults who have a diagnosis of dementia; on the day of the visit there were 14 individuals in the ward. Ward 4 is considered as a transition ward for older adults who will be returning home with packages of care to support their discharge or move into longer term placements in care homes. Most people in Ward 4 had initially been admitted to Ward 3 then transferred to Ward 4.

Since our last visit, senior managers in NHS Fife had notified the Commission that there had been a move of those who had previously been in Ward 1 to the newly refurbished Ward 3. We had last visited Ward 1, in November 2024 on an announced visit and made no recommendations.

We last visited Ward 4 in January 2025 on an announced visit and made one recommendation about the legal authority of treatment. The response we received from the service was detailed in an action plan.

On the days of the visit, we wanted to follow up on the previous recommendation and to hear about individuals' and staff experience of being in the newly refurbished environment. We were also keen to hear about individuals experience when admitted to Ward 3, as this ward continued to admit people with diagnoses of functional and organic mental illness.

Who we met with

In Ward 3, we met with six individuals in person and reviewed the care records of eight individuals. We also met with three relatives.

In Ward 4, we reviewed the care notes of five individuals. We also met and spoke with five sets of relatives.

Over the two days we spoke with the clinical services manager, the senior charge nurses (SCN) in both wards, the lead nurse, the consultant psychiatrist, the activity co-ordinator, a student nurse and other ward-based nursing staff. At the end of the day feedback meeting with managers, we also met with the associate medical director and associate director of nursing.

In addition, we met with an advocate from Voiceability advocacy services.

Commission visitors

Tracey Ferguson, social work officer

Denise McLellan, nursing officer

Susan Tait, nursing officer

What people told us and what we found

In Ward 3, we were able to have more detailed conversations with individuals who had been admitted for assessment, whereas in Ward 4 we were not able to have these types of discussion because of the progression of people's illness.

We were able to introduce ourselves to most of the individuals in Ward 4 and we had the opportunity to observe people in the ward environment; we found that individuals appeared settled and relaxed. We saw supportive interactions between nursing staff and individuals across both wards during our visit. This was evident during activities and while support was being offered to individuals with stress/distress behaviours.

We heard from staff in Ward 4 that due to the complexity of individual needs, there were particular times of the day where a higher staff ratio was required, for example at mealtimes. We observed this on the day of the visit.

The feedback from individuals we met in Ward 3 was mostly positive. Individuals told us that they felt involved in their care and treatment and met with the doctor regularly to discuss this. Individuals told us about the activities that they were involved in, on and off the ward. Individuals described the staff "nice", "good" and "approachable". Several people we spoke with were able to tell us about the reasons why they were admitted, including what their rights were, which was positive to hear. A few people we spoke with told us that the ward could be noisy and with the added works that were being carried out in the ward underneath Ward 3, this added to the continued daily noise.

Relatives we spoke with told us that the staff were experienced and knew their relatives well. Some relatives provided examples where they had met with the doctor to discuss their relatives care and treatment, which made them feel involved. Some relatives describe the care as "personalised".

We heard from relatives that the communication was good and that the staff kept them up to date with their relatives care and treatment, when they either contacted the ward or visited. One relative told us there was "great care and treatment being provided".

We heard from one relative that it would have been helpful to have the staff teams pictures on a notice board, rather than just the names of the staff on the shift. One relative told us that they were unsure about activities that were in place and what activities their relative had been involved in. Most relatives knew about the care plans and told us that they could access these if they wished.

In Ward 4 relatives told us that the staff were "amazing", "experienced" and "excellent". One relative described their experience as being treated with "kindness, courtesy and respect". Another relative told us that they did not want their relative to

move on from the ward as the staff had gotten to know them so well and were experienced in providing dementia care. Some relatives told us that they had met with the doctor and attended meetings to discuss the next steps, including discharge plans, but we also heard from other relatives that there had been, on occasions an inconsistent approach to their relative's care. This has been when a member of bank or agency staff had been on shift and did not know their relative as well as the regular cohort of staff.

All relatives were able to tell us about the process of raising any issues of concern. One told us about the impact that their caring role had had, leading to the admission of their relative and that staff were supportive in listening to the change that this had brought about and referring them onto the relevant carer's agency.

We heard from relatives across both wards that visiting times were flexible which enabled them to continue to support their relatives at various times of the day.

On our last visit to Ward 1, relatives had mentioned they would find having a welcome pack helpful, particularly for the early days of an admission to hospital and to know what to expect. For this visit, we brought this to the attention of the leadership team and were told that there was an information pack currently in draft form with the intention to share this with relatives soon. We look forward to seeing the progress with this on our next visit.

Across both wards relatives told us that they had good input from mental health officers (MHO) and social workers and were provided with information regarding rights and legal frameworks.

We met with the consultant psychiatrist who told us that they had taken up post quite recently and we heard that the team had been very welcoming and supportive.

We met with an advocacy worker who told us that most referrals came from MHOs to support people with their rights. They told us that they were made welcome on both wards.

Staff across both wards told us that they were thrilled with the new environment in Ward 3 and spoke about how the new environment was already benefiting individuals and staff. We heard how there was more space to have one-to-one and family meetings and that having the separate meeting room was great as both wards could access this. The student nurse told us that the ward was a supportive environment that provided a good learning culture.

The SCN in Ward 3 had recently taken up this promoted role and we were told that the advert for a permanent SCN for Ward 4 was due to be advertised soon. Ward 4 had had an interim SCN in post for the past three years. It was positive to hear that

there were very few staffing vacancies across both wards, however we were told that due to high sickness levels in Ward 4, regular bank and agency staff had to be used.

Staff in Ward 3 told us about the difficulties and challenges of having a mix of people in the ward with both functional and organic mental illness diagnoses. We understand that there will be times when someone with a dementia diagnosis is admitted to a ward for people primarily with a functional mental illness. This is appropriate when a person with dementia requires assessment and treatment for a concurrent functional mental illness, or are early in the process of diagnosis, when it is unclear if the person has a functional illness or dementia.

In general, we do not think that mixed wards meet the needs of either group. In 2020, the Commission published a themed visit report into older people's functional mental health wards. Since then, many health boards have taken measures to separate this service provision which has led to better outcomes for people.

Staff told us that they pulled together as a team and supported each other. We heard from the SCNs that due to staffing levels, they were sometimes counted in the numbers, which had an impact on their ability to meet their own duties associated with the SCN role. Some staff members told us that they have had to provide cover to other wards and that community staff had also to provide cover to the wards. One staff member told us that they felt experienced to provide cover to the ward as they were working in a community mental health team for older adults, although we also heard from others that it could be difficult if they were moved to another area, particularly if this was out with the skills they had developed in their own speciality.

We are aware that the health board are undertaking work with Healthcare Improvement Scotland (HIS) to ensure safe staffing levels and that the ward is required to meet the obligations of the Health and Care (Staffing) (Scotland) Act, 2019. The lead nurse and SCN told us that in order to ensure safe staffing levels were in place there was a staff huddle each morning that involved the senior staff team; this was to ensure wards had sufficient staffing to meet the clinical needs and demands in each area.

The associate nurse director informed us that up until recently, staff were moving only across mental health services however, this had now expanded out to the general and community hospitals and that cover was mainly required by the health care support workers (HCSWs).

Care, treatment, support, and participation

On reviewing the care records, each person had a completed nursing assessment following admission to the ward. These assessments were detailed and outlined the reason for admission and outcome to be achieved. Everyone had a care plan in

place, and the majority of care plans were detailed, person-centred and covered a wide range of needs for each person.

Across both wards there was evidence of regular reviews of the care plans, however we noted a few care plans in Ward 4 where there had been gaps in the review timescale. We were able to see where individuals and relatives had been involved with the care planning process, although we saw others where the involvement and participation of the individual and/or relative was less clear.

We found that the level of detail in the stress/distress care plans was good however, we saw some care plans which would have benefitted from more detail regarding the intervention techniques required.

We would like to have seen a clear focus on the use of non-pharmacological strategies to reduce symptoms of stress and distress behaviours, with staff following the care plan and applying these interventions before considering the use of medication. In Ward 4, we found in some of the care records that the recorded detail in the nursing notes was lacking in this area.

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

Recommendation 1:
Managers should ensure that all nursing care plans across the service detail all 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.

In Ward 3, we saw that one-to-one discussions were taking place regularly although they did not always capture the views of the person. We suggested to the SCN to try and record the individual's views about their rights, care and treatment during the one-to-one discussions to promote involvement and participation.

In Ward 4 we saw some daily recordings by staff that recorded 'evident in the ward' and 'settled at bed space'. Given the complexity of the individuals in this ward, we would have expected to see more detail in the level of recording of the individual's presentation on that specific day.

We found nursing entries in two sets of care records in Ward 4, where pejorative language was used without any context. These words described individuals as being "brittle", and "disgruntled'". We provided examples of these individual records to the senior managers at our feedback session.

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

We found that the entries recorded by the activity co-ordinator, music therapist and physiotherapist were very detailed, outlining the outcomes achieved on that day.

We found clear recording of discussions between nursing staff and relatives across both wards and we suggested it may be helpful to record the agreement regarding the level of contact in the individual care plans.

We found that there was robust physical healthcare monitoring in place, which was evident in the care records.

Everyone across both wards had a risk assessment and risk management plan in place that were mostly detailed with evidence of reviews taking place. However, the level of detail in some of the reviews varied. We requested the SCN to review one individual's risk assessment and risk management plan as this person had been discharged and re-admitted but the document lacked this important detail.

Care records
Information about individuals' care and treatment was held in the electronic system, MORSE. We found it easy to access daily recordings, minutes of meetings, and attachments. For documents such as care plans and risks assessments, access to these was more difficult in some cases across both wards.

We were told that there were specific sections where the staff member would develop and store these documents, but this was not always clear. We also heard similar concerns from staff, who told us that it was not always easy to find certain documents, as this could depend on who had added the document to the system.

Recommendation 2:
Managers must ensure that there is a clear process to guide the storage of documents on the electronic recording system that all staff are familiar with.

Multidisciplinary team (MDT)

There were a range of disciplines providing input in Wards 3 and 4, including nursing, consultant psychiatrist, activity therapist, medical staff and music psychotherapy (only Ward 3). In addition, there was input from allied health professionals (AHPs) such as dietician and occupational therapist (OT). Pharmacy provided input to the wards and attended MDT meetings.

While the clinical team recognised the importance of a holistic model of care and treatment, we were disappointed to hear about the lack of input from psychology in individuals care and treatment. On our last visit to Ward 1, we heard how staff were keen to promote a psychological formulation approach, and although this continued to be the ethos, unfortunately the lack of psychology provision towards people's care and treatment was lacking throughout the care records.

The clinical services manager informed us that there had been a change of provision due to vacant posts. The wards continued to have some input from this professional discipline however, it was minimal and more input was required. The service acknowledged the benefit and importance of this role towards peoples' care and treatment and was looking to recruit. We will request an update from the clinical services manager in three months' time.

In both wards the MDT met weekly to discuss individuals' presentation, progress and any interventions that were required to ensure care and treatment met the needs of individuals. The SCN told us that Ward 3 had a new MDT template in place, and that Ward 4 was going to be implementing this format soon. We found records of those meetings were detailed, consistent with recorded actions and outcomes.

It was difficult to see where the person and families' views were captured at these meetings. While we saw separate family meetings being held and some attendance at the MDT meeting, it was difficult to see where the consultant psychiatrist had met and reviewed the individual's care and treatment and sought their views.

Recommendation 3:
Managers must review the minimum timescales for in-person medical reviews for all individuals in the ward and ensure this is clearly recorded.

We saw that social workers and MHOs were also in attendance at some of those meetings, although we were told that the appointed service-based social worker for the wards no longer attended the weekly meetings and that this had stopped due to financial and workload pressures. We had heard previously that this role had a positive impact, bridging the gap between the hospital and the community/local authority, so the service had noticed a loss with them no longer attending. We were told that there was going to be further discussions around this.

There were five individuals who had been identified as having their discharge delayed from hospital-based care, there were four in Ward 4 and one in Ward 3. There were specific reasons for the delays, typically in relation to arranging suitable nursing homes, care packages and awaiting welfare guardianship orders. The ward-based team continued to be supported by a discharge co-ordinator. This role was valued, and we heard that communication between services, including nursing homes, had greatly improved. There were close links between the ward-based and community mental health teams.

Use of mental health and incapacity legislation

On the day of our visit to Ward 3, there were seven individuals who were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). In Ward 4, there were 10 individuals who were detained under the Mental Health Act.

For both wards, the Mental Health Act detention paperwork was easy to locate in the 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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place in Ward 3. However, in Ward 4, we found discrepancies in two people's certificates where medication had not been authorised and one further discrepancy in one individual's certificate.

We had been told that the wards had a regular and robust audit system in place, so it was disappointing to find these errors. We were told that when issues were raised, action was not always being taken, which was concerning to hear.

Recommendation 4:
Managers and responsible medical officers (RMOs) must ensure that all psychotropic medication is appropriately and legally authorised and that regular audits undertaken to ensure significant improvement in this area are maintained and that any escalated matters are promptly addressed.

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 this information was recorded in the person's file.

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 (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.

In Ward 4, all individuals had an AWI Act section 47 certificate in place, along with an accompanying treatment plan; in Ward 3, nine people had a section 47 certificate in place, along with an accompanying treatment plan. We found some treatment plans recorded 'discussion for discharge' which was not appropriate on a section 47 certificate where it is for the purpose of medical treatment and does not authorise welfare matters. There were also a number of certificates where there was no evidence of consultation with the power of attorney (PoA) or welfare guardian.

Following our visit to Ward 4 in 2023, we made a recommendation in relation to the AWI Act, specifically for staff to ensure that where a section 47 certificate was in place, all welfare guardians/ powers of attorney had been consulted and their opinion or agreement was recorded. We had been told on our visit to Ward 4 in 2024

that clinical staff extended their compliance with the AWI Act by undertaking audits and additional training to ensure all staff were knowledgeable about their responsibilities with this legal framework. It was disappointing to see that any improvement that had taken place has not been sustained.

Recommendation 5:
Managers must ensure that section 47 certificates and treatment plans have been completed in accordance with the AWI Act code of practice for medical practitioners and that certificates are reviewed when a person is transferred to the ward. Consultation with proxies must take place when practicable and be recorded.

Where there was a PoA or welfare guardianship order in place we found all documents easy to locate.

For individuals who had covert medication in place, all appropriate documentation was in order, and all had recorded the reviews or documented the pathway where covert medication was considered appropriate.

The Commission has produced a good practice guidance on the use of covert medication.[2]

The Scottish Government produced a revised policy on do not attempt cardio-pulmonary resuscitation (DNACPR) in 2016.

This makes it clear that where an adult cannot consent and has a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give or not to give CPR. Where there is no guardian or attorney for a person who cannot consent to a decision about CPR, it is a requirement to consult with close family, as well as to note what steps need to be taken to establish the wishes of the individual. In all cases, this involvement or consultation should be recorded.

In Ward 3, DNACPR forms were completed, with evidence of discussion with nearest relative or proxy, as appropriate. In Ward 4, we found some where there was no record that a discussion had taken place or been recorded on the certificate. We found that these certificates were often completed in another hospital and we therefore advised that the MDT should review these and ensure there was a discussion with families/proxies on transfer.

Rights and restrictions

Wards 3 and 4 continued to operate a locked door, commensurate with the level of risk identified in the ward population. A locked door statement was displayed outside each door. We were informed from other visits that we had carried out that the NHS

[2] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492

Fife locked door policy was being reviewed. We have requested that senior managers keep the Commission updated with regards to this policy.

When we review individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under section 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 responsibly for promoting advance statements. Most individuals in Ward 3 and Ward 4 would be unable to write their own advance statement. Nevertheless, to ensure individuals are supported to participate in decisions, the clinical team should be able to evidence how they have made efforts to enable people to do this and clearly record if a person has been assessed as not being able to complete an advance statement.

We were told that advocacy attended the ward regularly and supported individuals in relation to Mental Health Tribunal for Scotland hearings and with their rights.

For individuals who were being supported under continuous intervention, we found that the documentation in use was very dated and still referred to outdated terms, such as 'constant observation' and 'general observation'.

The Scottish Patient Safety Programme (SPSP) had produced 'Improving Observation Practice' (IOP) guidance. The focus of the IOP guidance was to replace the enhanced observation practice with a continuous intervention framework of proactive, responsive and personalised care and treatment, which focuses on prevention and early intervention where there is a deterioration in mental health. IOP determines and describes the nature and extent of care, treatment and safety planning, and associated interventions and interactions that an individual requires, based on their assessed needs.

We discussed this further with senior managers at the end of day feedback session and were told that the NHS Fife observation policy was being reviewed, although it was not near completion. To hear that the SPSP IOP guidance had not been implemented was concerning and we will continue to follow this up with senior managers.

Recommendation 6:
Managers must prioritise review of the current observation policy to ensure it aligns with the Scottish Patient Safety Programme 'Improving Observation Practice' guidance and supports observation practice that is personalised, proactive and responsive.

We found that when speaking with individuals and relatives they were aware of their rights however, we felt that it would be helpful for the service to enhance their

recording around individual rights, particularly for people admitted to the ward on an informal basis or develop a specific rights-based care plan.

The Commission has developed *Rights in Mind.*[3] 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

The wards had a dedicated activities co-ordinator that covered both wards. We observed individuals engaging in activities and socialising with their peers and relatives on the day of the visit. Some of the activities were ward based but some also took place in the community.

Ward 3 had a weekly session provided by music psychotherapy which we saw on the day of the visit. Although Ward 4 did not have a session, we were told that where it was considered appropriate, some people from Ward 4 attended the session in Ward 3. We were able to observe individuals engaging enthusiastically during this session, using instruments, singing and dancing.

The ward-based team recognised having a programme of activities available for individuals was not only contributing positively to their care and treatment but often provided a psychologically approach to managing stress/distress behaviours.

Across both wards everyone had a completed 'getting to know me' document which provided detailed information about peoples likes and dislikes as well as their personal history.

The physical environment

Over the last year we had received regular updates from the senior leadership team about Ward 3 and were pleased to hear that the ward had moved to the newly refurbished ward towards the end of 2025. Ward 3 was based upstairs and is next to Ward 4.

Ward 3 was bright, spacious and other rooms had been created to enhance the persons' experience during admission, as well as improving the environment for staff. Ligature reduction works had been carried out.

There was now a separate MDT room, a relaxation room, and a treatment room. We heard from staff that there had been some 'teething' problems, which was to be expected however, the environment had improved their wellbeing.

The ward continued to have dormitory style accommodation as well as single ensuite rooms; some single rooms were without ensuite. Each dormitory had

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

sufficient bed space for four people and there was a large level-access shower room in the dormitory. New windows enabled fresh air into the ward. There was a spacious dining/lounge area with a kitchen off this room that enabled staff to serve the lunches and make snacks/drinks. There was also a separate activity room.

Throughout the day it was noisy on the ward due to the refurbishment that was happening in the ward below. Staff told us that there were times that they had to ask the work to stop due to distress experienced by some people. It was hoped that the refurbishment works will be complete by the summer months.

In Ward 4, there continued to be the 'serenity café' for individuals and their relatives to enjoy during visits. This ward also had a mix of dormitory style bedrooms and single en-suite bedrooms. Each dormitory had a large level-access shower room off the dormitory. There was also a separate bathroom on the ward and other separate toilet facilities and a large lounge dining area. This ward had gone through a considerable re-fresh over the past two years, and we heard of future refurbishment plans for this ward that are similar to Ward 3, along with investment in other areas across the Fife estate. We will continue to request updates from senior managers regarding these plans.

Summary of recommendations

Recommendation 1:
Managers should ensure that all nursing care plans across the service detail all 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 there is a clear process to guide the storage of documents on the electronic recording system that all staff are familiar with.

Recommendation 3:
Managers must review the minimum timescales for in-person medical reviews for all individuals in the ward and ensure this is clearly recorded.

Recommendation 4:
Managers and responsible medical officers (RMOs) must ensure that all psychotropic medication is appropriately and legally authorised and that regular audits undertaken to ensure significant improvement in this area are maintained and that any escalated matters are promptly addressed.

Recommendation 5:
Managers must ensure that section 47 certificates and treatment plans have been completed in accordance with the AWI Act code of practice for medical practitioners and that certificates are reviewed when a person is transferred to the ward. Consultation with proxies must take place when practicable and be recorded.

Recommendation 6:
Managers must prioritise review of the current observation policy to ensure it aligns with the Scottish Patient Safety Programme 'Improving Observation Practice' guidance and supports observation practice that is personalised, proactive and responsive.

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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