Mental Welfare Commission for Scotland

Report on unannounced visit to: Islay Centre and Carnethy House, Royal Edinburgh Hospital, Edinburgh, EH10 5HF

Date of visit: 13 November 2023

Where we visited

The Islay Centre comprises of three units, with a total of 11 individualised areas that combine day/sleeping areas for individuals. In addition to this unit, Carnethy House provides a service for another two individuals. Both units are based in the grounds of the Royal Edinburgh Hospital. This service provides assessment and treatment for individuals with a learning disability, who have significantly complex and challenging behaviours, often associated with a diagnosis of autistic spectrum disorder.

On the day of our visit, there were 13 individuals in Islay Unit and Carnethy House; there were seven delayed discharges, which was the same number as the previous Commission visit in 2022. We heard that no discharges had progressed since our last visit however, we heard that three individuals in Islay Centre and Carnethy House were actively involved in discharge planning.

We last visited this service in October 2022 and made recommendations in relation to care planning, psychology provision in the ward, the quality of the recording of the multidisciplinary meeting, individual and carer participation, recording of enhanced observation, review of the seclusion policy, promotion of advance statements, recording and evaluation of activity, and addressing environmental issues.

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

Who we met with

We met with, and reviewed the care of seven individuals, all of whom we met with in person. We also spoke with two relatives/carers.

We spoke with the two senior charge nurses (SCN), nursing staff, and the art and music therapist. We met with the clinical nurse manager (CNM) and made contact with Volunteering Hub based at The Royal Edinburgh Hospital following the visit.

Commission visitors

Kathleen Liddell, social work officer

Anne Buchanan, nursing officer

Tracey Ferguson, social work officer

Dr Juliet Brock, medical officer

What people told us and what we found

Care, treatment, support and participation

Due to the progression of their significant communication difficulties, as a result of their severe/profound learning disability, we were unable to have detailed conversations with some of the individuals. However, throughout the day we introduced ourselves and spoke to some who were happy to engage with us. Some of the individuals were able to respond to our interactions by using non-verbal communication such as smiling and using hand gestures. We observed positive interactions between ward staff and individuals during our visit and it was evident from these observations and discussions with staff that they had a good knowledge and understanding of those they provided care and treatment for.

We noted that staff had adopted their own individualised approach to communication, with individuals using a variety of different methods, such as the use of signs and object signifiers. We observed that staff had a good understanding of the individuals' sensory needs and responded in a therapeutic way to meet these. An example of this was a nurse responding to an individual's stress and distress by focussing on sensory pressure points. We saw how this personalised intervention was beneficial to that individual and instantly reduced their level of stress and distress.

We met with an individual who told us that staff were "brilliant" and had "helped make my dreams of being discharged from hospital come true". The individual was aware of, and had participated in, their care plan; they were happy with their timetable of activities which included employment, engaging in community supports, and engagement with third sector and volunteer services. We heard that the individual was preparing for discharge from hospital and felt fully involved in decision-making. The individual told us that the 'liaison meeting' was very supportive as all key staff, family members and the individual had attended to discuss discharge planning. We heard that the individual had a key nurse who offered regular one-to-one support and that they liked and trusted their key nurse. The individual did not attend the multidisciplinary team (MDT) meeting as they found the meeting "too stressful".

The carer/relatives we spoke to provided mixed feedback about the care and treatment their relative was receiving. All carers/relatives told us that most of the staff were very caring and showed compassion and empathy to their relative. We were told that many of the staff were committed to supporting the individuals in Islay Centre and Carnethy House. We heard that the discharge planning progress was variable, although where discharge was imminent, the carer/relative felt involved in discussion and decision-making. One relative/carer commented that the introduction of the Care Programme Approach (CPA) had been beneficial in promoting full MDT discussion, decision-making and accountability. Another carer/relative raised that they did not feel listened to by senior medical staff in ward, and were not part of discussion and decisions that were taken.

Both carer/relatives spoken to told us that they felt the environment was 'institutionalised'. We heard from one that they considered their relative had complex needs and felt that at times, the staff team did not know how to manage the complexities and therefore 'locked' their relative in their room. This was a concern for the relative/carer as they felt their relative was isolated and secluded, and was not being given the opportunity to make any progress.

This led to concerns that their relative would have a prolonged hospital admission. We raised this matter with the SCN, who acknowledged that staff shortages and the absence of a Positive Behaviour Support (PBS) model had been a factor for the seclusion.

Care records

Information on individuals' care and treatment was held electronically on TRAKCare; we found this easy to navigate. The majority of care records were recorded on a pre-populated template with headings relevant to the care and treatment of the individuals in Islay Centre and Carnethy House. It was evident from reviewing the care records that individuals in both units had complex needs and required skilled nursing intervention. The individual group could experience high levels of stress and distress, leading to increased clinical risk due to the frequency and extent of verbal and physical aggression. It was evident from reviewing the care records that it was the nursing staff who provided the majority of care and support to individuals at times of stress and distress. There was evidence of frequent one-to-one interactions between individuals and nursing staff.

Most of the care notes we reviewed were of a good standard and evidenced person-centred, individualised recording, detailing what activities the individual had engaged in that day and what had been positive or challenging. We were pleased to see that the care records focussed on the strengths of the individuals. This strengths-based approach was also evident during more challenging circumstances, such as when incidents of aggression had occurred.

We made a recommendation in the previous report in relation to all members of the MDT recording in care records. We were pleased to see progress in relation to this; now, nearly all members of the MDT record their involvement however, we remain concerned that there was no recording by senior medical staff in the care records we reviewed.

We were pleased to see and hear that all individuals were subject to the Care Planning Approach (CPA). The CPA meeting documentation was of a high standard and evidenced assessment, review and coordination of the care and support needed for the individuals. We saw that where appropriate, individuals and family members attended the CPA meeting and were involved in discussion and decision-making. We were pleased to note that for some individuals, they were supported by advocacy to attend their CPA meeting.

For individuals where discharge planning was progressing, we saw clear evidence of involvement from the MDT, the individual, and where appropriate family and/or the welfare guardian, as well as community services and third sector providers. We saw that there were regular discharge and decision-making discussions recorded as part of the MDT and liaison meetings. The purpose of the liaison meeting was to discuss future planning, the model of care being provided, alongside any issues and/or positives aspects in the individual's care and treatment. One individual we met with spoke positively about the liaison meeting and found it beneficial in supporting the transition to their community placement.

We discussed the ongoing number of delayed discharges with the SCN and were told that this was mainly due to a lack of community provision. We heard that for some individuals, they had been near to discharge however, due to difficulties with securing community supports, the discharge had been delayed.

Nursing care plans

Nursing care plans are a tool which identify detailed plans of nursing care; effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

Individuals in Islay Centre and Carnethy House had various treatment plans relevant to their care goals that were held in paper files. The treatment plans we reviewed were comprehensive and held detailed information, reflecting the complexity of the care that was being provided in the units. We found that there was an increased use of communication passports and 'Getting to Know Me' documentation that promoted the recording of personalised and person-centred information. We noted an improvement in the individual's participation in care planning which was supported by use the use of symbols, signifiers and input from speech and language therapists. We heard that the service was hoping to implement the health and recovery care plan as discussed during our previous visit however, this had not yet happened. We were told that there was an imminent plan for the introduction of these plans into both units.

We saw that physical health care needs were being addressed and followed up appropriately.

There was no evidence of regular or robust review of the treatment plans. We saw from reviewing the CPA and MDT meetings that progress and changes had been made to care planning however, this was not reflected or recorded in the treatment plans. We were concerned as to whether the information recorded in the treatment plans remained relevant to the individual's current care and treatment goals.

The risk assessments we reviewed were, on the whole, detailed and provided comprehensive information on identified risks and how the individual would be supported to manage and minimise risk. We found that some risk assessments had not been reviewed for a prolonged period of time and raised this with the SCN on the day of the visit.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:
https://www.mwcscot.org.uk/node/1203

Recommendation 1:
Managers should implement a system for the regular audit of care plans to ensure consistency in quality of content, recording and review.

Multidisciplinary team (MDT)

The unit had a MDT on site consisting of a part-time consultant psychiatrist, a part-time speciality doctor, nursing staff, two occupational therapy staff, pharmacy, a music therapist, an art therapist and three recreational assistants. We heard that the speech and language therapist left post recently and this post had not been filled as yet.

We were advised that the recommendation in the previous report in relation to the provision of medical staff in Islay Centre and Carnethy House had not been progressed. We were concerned to hear that medical provision had been further reduced from our last visit by one session a week. From reviewing the care records, and discussions with staff and

relatives/carers, we were concerned about the reduced provision of the medical resource and leadership in both units for a highly complex population. We heard that other learning disability wards in the hospital had a higher level of medical provision available and were unclear why there was a lack of parity across the learning disability service.

Similarly, we heard that since the previous visit, there had been no progress on psychology input into the MDT. We were told that the vacant psychology post had been advertised for some time, with no applicants. The lack of psychology input to individuals in Islay Centre and Carnethy House was a significant concern to the Commission. We heard and saw that the lack of psychology input had a detrimental impact on individuals in the units, mainly related to the creation and implementation of PBS plans. The Scottish Government *Coming Home Report* (2018) highlights PBS to be well established and evidenced-based for its effectiveness in supporting people with complex needs and behaviours. PBS requires joined up working across the MDT to ensure staff understand their role of formulating, assessment and implementation. The lack of psychology input has prevented the appropriate supervision structure available for PBS trained nursing staff to implement this in a confident and supported manner. Again, we heard that other learning disability wards on the hospital site had access to psychology, and while we appreciated that there was a pressure on psychological services, we would have expected managers of the service to review the provision that was available, to enable parity across the wards.

The MDT meetings took place weekly and discussed individuals on a fortnightly basis. We made a recommendation in the previous two reports in relation to the quality of MDT information recorded in the Coreplan. We were pleased to see that significant progress had been made and the MDT meeting was recorded on the structured ward template and stored on TRAKcare. The MDT records we reviewed were comprehensive, and provided detail on all aspects of the individual's care planning. We heard that individuals and relatives/carers were invited to attend the MDT however, liaison and CPA meetings were better attended. We were pleased to see this increased involvement from individuals and carers/relatives in discussion and decision-making. Where individuals were unable to be involved, reasons for this were regularly recorded.

We were told that there continued to be a number of vacancies with band 3 health care support worker and band 5 nurse vacancies, approximately 24 in total. We heard that proactive recruitment initiatives, such as attending universities to meet with nursing students and holding three open days, had been arranged to promote recruitment; unfortunately, this recruitment strategy has not yet been successful in getting new staff. We were advised that bank staff usage was high, although it was positive to hear that the bank staff that were used knew the individuals well. We heard from the CNM that ongoing recruitment initiatives would continue however, there was a concern that the staff shortages would negatively impact on the current staff who were experienced and skilled. We heard that support for staff retention as well as recruitment was being prioritised. Staff were offered regular supervision and team meetings as well as mentalisation support on a one-to-one or group basis, provided by an external psychologist. We were told that staff valued the mentalisation support.

Recommendation 2:
Managers should urgently review the level of medical and psychology provision in the unit, with a particular focus on ensuring parity of provision across the learning disability estate.

Use of mental health and incapacity legislation

On the day of our visit, all of the individuals in Islay Centre and Carnethy House were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The individuals we met with during our visit had a good understanding of their detained status. Many were also subject to the Adults with Incapacity (Scotland) Act 2000 (the AWI Act).

All documentation relating to the Mental Health Act was recorded on TRAKcare and in paper files. We found that paper files had extensive Mental Health Act documentation which was unnecessary; we raised this with the SCN and suggested that a review of the paper files would be useful to ensure that only current documentation is held in paper files on the ward.

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

We reviewed the prescribing for all individuals, as well as the authorisation of treatment for those subject to the Mental Health Act.

Medication was recorded on the hospital electronic prescribing and medicines administration (HEPMA) system. T2 and T3 certificates authorising treatment were stored separately on TRAKcare. On cross-checking the electronic records for each individual, we found that many detained individuals were prescribed treatment, without the necessary legal authorisation in place. We provided details of the individuals to the responsible medical officer (RMO) and requested an urgent review.

On the day of the visit, we found the details of welfare proxies and the powers granted in the welfare and/or financial guardianship orders for individuals who were subject to the AWI Act legislation. The individual we met with, who was subject to guardianship under the AWI Act had a good understanding of what this meant for them.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate 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 were unable to locate a s47 certificate in one file. We raised this with the SCN on the day of the visit and contacted the RMO to make them aware. We found that many of the individuals were receiving treatment for specific physical health conditions, but this was not reflected in their treatment plan. All of the s47 certificates we reviewed had an identical generic treatment plan. We would expect treatment plans to be individualised in accordance with the person's specific medical needs.

Recommendation 3:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, record a clear plan of treatment, and that all psychotropic medication is legally authorised.

Recommendation 4:
Managers and the responsible medical officers must ensure individuals who lack capacity in relation to medical treatment have s47 certificates and where necessary, treatment plans completed in accordance with the AWI code of practice (3rd ed.), to cover all relevant medical treatment the individual is receiving.

Rights and restrictions

Islay Unit and Carnethy House continue to operate a locked door, commensurate with the level of risk identified with the individual group. Information on the locked door policy was available at the main entrance to the unit.

During the last visit, we highlighted that continuous observations were in place for many of the individuals in Islay Centre and Carnethy House. We found limited change to the use of continuous observation during this visit. We saw that for some of the individuals, enhanced observation had been in place for prolonged periods. In our last visit report, we mentioned NHS Lothian's Standard Operating Procedure: *The practice of continuous interventions in mental health wards*; this procedure recommended that continuous intervention should be reviewed regularly to assess its effectiveness and promote a framework of practice that is proactive, responsive and personalised. We were disappointed to find that limited reviews of continuous observation was being undertaken.

Two individuals continued to be observed with the use of CCTV cameras in their rooms. We reviewed both of the individuals care records and saw a treatment plan detailing the requirement for the use of CCTV. We were concerned that one individual, had been assessed as requiring two-to-one nursing intervention however, it was recorded on the treatment plan that CCTV was used at times when staffing levels were unable to provide this level of intervention. This raised concerns that the use of CCTV was, at times, service led and not led by the needs of the individual. We discussed the use of CCTV with the CNM and SCN and were told that the CCTV was not an alternative to staff intervention. We heard that for one individual, who was only able to engage with core staff on a face-to-face basis, if core staff were not available due to staff shortages, CCTV was used as it was less distressing to the individual than engaging with unfamiliar nursing staff. Although we understood the staffing pressures on the service, we raised our concerns that the disproportionate use of CCTV may be an intrusion into an individual's privacy and dignity which is protected by article 8 of the European Convention on Human Rights. The presence of a camera may be deemed a threat to individual privacy and must be proportionate, for a legitimate aim, and lawful.

We highlighted concerns regarding the use of seclusion for some individuals in our previous report. While we were pleased to hear that there had been a reduction in the use of seclusion rooms in the units, we remain concerned that many individuals were secluded in their bedroom areas. During review of the care records, we found some seclusion care plans which recorded the requirement for this practice however, we were concerned that there was no regular

evaluation to minimise the use of this restrictive intervention. For other individuals, we identified their situation as seclusion as they were confined to their bedrooms, some of which were locked, for prolonged periods of time and subject to frequent levels of staff observation. We were told by staff and relatives/carers that a lack of staffing and the inability to implement PBS was a factor in some individuals requiring seclusion. We heard that for some individuals, the implementation of PBS would address these levels of restriction and provide an effective framework for supporting the complex needs and high-risk behaviours.

Our good practice guide *Use of seclusion* is available on our website.

We were pleased to hear that the level of restraint in both units had reduced. Islay Centre had recently purchased a safety pod to use if restraint was needed. We heard that the safety pod promoted a more dignified, safe and compassionate approach to restraint for individuals who required it.

When we are reviewing individual's files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under ss274 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. It was evident from meeting individuals and reading their care records that they did not have the level of capacity required to make a valid advance statement. The Commission good practice guidance on advance statements is clear that the person making an advance statement, has to have the 'capacity of properly intending' the wishes specified in it. While we did not find any advance statements, we were pleased to see that the CPA documentation discussed advance statements and recorded whether an individual was able to participate in the making of an advance statement. We discussed with the SCN that it remained important that any wishes or views the individuals may have, were considered when making decisions regarding care and treatment.

Our *advance statement good practice guide* is available on our website.

We heard from individuals that we met with, and the staff, that advocacy support was available on the ward. Partners in Advocacy attended the ward regularly and we were pleased to hear that they had regular discussions with the MDT regarding how best to engage with those individuals who would benefit from their input. Advocacy were supporting individuals who were involved in discharge planning and attended liaison and CPA meetings.

We were pleased to note that many of the files we reviewed, recorded that the individuals had legal representation. For those individuals unable to organise legal representation, a curator ad litem had been requested to safeguard the interests of the individual in proceedings before the Mental Health Tribunal for Scotland.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Individuals have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Recommendation 5:
Managers should ensure that the need for enhanced observation is clearly recorded, and staff have access to and are conversant with the observation policy.

Recommendation 6:
Manager should ensure that an urgent review of the seclusion policy is undertaken to ensure all seclusion is required, regularly evaluated, and included in the individual's care plan.

Activity and occupation

We heard Islay Centre and Carnethy House had three dedicated band 3 recreational assistants. The role of the recreational assistant is to support individuals to develop person-centred activity planners that include social, recreational and rehabilitation activities. We noted that the OT staff had completed assessments, some of which focussed on skill development and enhancement. We found personalised activity timetables relevant to each individual's care and treatment goals; activity and occupation were delivered both in the ward and in the community.

The activities available in the unit included access to music therapy, input from Cyrenians' garden project, swimming, local walks, bus outings in the community, cycling, and therapets attending the ward. We heard that staff had organised a sponsored walk and the funds were used to arrange therapy ponies. We saw photographs of individuals enjoying spending time with the ponies and heard from an individual that they "really enjoyed having the ponies in the unit". Given the success of this activity, staff were hoping to arrange a further session.

We met with the music therapist and were told that music therapy was provided to individuals on a one-to-one basis. The purpose of the intervention was to reduce isolation and promote social interaction. For one individual, we read about the positive impact music therapy had provided. We heard that the individual was engaging for longer periods of time in the activity and their participation and engagement was increasing each week.

In addition to activities offered by staff, we saw a number of individuals who were supported by third sector providers as part of their transition in preparation working towards discharge.

We were pleased to find an improvement in the recording of activities by all staff. We found the music therapy sessions records to be comprehensive, personalised and provided detail on the purpose of the intervention, level of engagement, progress made and future plans.

We contacted the Volunteering Hub based at the Royal Edinburgh Hospital following the visit. We were told that volunteers attended the Islay Centre weekly to provide therapet sessions. We were pleased to hear that funding had been secured from Action Earth and there were plans in place to develop the gardens into a more therapeutic space for some individuals.

The physical environment

The Islay Centre is made up of three units, Harris, Rhum and Barra. In addition to the Islay Centre, Carnethy House provides care for a further two individuals.

Each unit in the Islay Centre is accessed separately. Harris can accommodate three individuals, with Rhum and Barra units accommodating four individuals per unit. Each unit has

individual ‘pods’ which include a bed space and en-suite facilities. The pods vary in size with some having room for a small living area with a TV and sofa. Each pod had access to an outdoor garden area. One individual showed us their garden area and we were impressed with the flowers and vegetables they had grown.

We were able to view some of the pods on the day of the visit, and saw that they were decorated to the individuals’ personal taste. We were pleased to see that for one individual, a significant improvement had been made to their environment which provided a less clinical and more therapeutic environment.

There is limited communal space in the units. We heard from one individual that they preferred spending time in their own area and would not use a communal space in the unit. However, during discussion with staff and relatives/carers, they advised us that it would be beneficial for individuals to have a choice as to whether they wanted to use communal areas. We heard that the communal areas available were not safe to be used and required hospital estates to make some adjustments to ensure the space was safe. We were told that a request had been made for this work to be progressed.

When undertaking a review of the units, we saw that improvements to the environment were required. While we noted that there was a high standard of cleanliness, we were concerned that no improvement had been made in relation to the décor being refreshed and repairs being completed. Specifically, the communal bathrooms were discoloured and there was evidence of mould. We saw that Carnethy House had a significant number of outstanding repairs. We were told that requests had been made for the repairs and painting however, there were prolonged delays with requests made to hospital estates. We heard however that there were plans for internal renovation, although these were at an early stage. While we were encouraged to hear about potential environmental improvements in the units, we suggest that this should not prevent essential repair and decoration work being completed.

Recommendation 7:
Managers must prioritise addressing the outstanding environmental issues in relation to updating fixtures, fittings, decoration, and maintenance issues to make the environment more homely and therapeutic.

Any other comments

We admired the level of commitment, skills and knowledge shown by the staff that we spoke to during the visit. We saw some positive interactions during the visit and it was evident that staff knew the individuals well. The individuals we spoke to told us how supported they felt by staff and relatives/cares endorsed this by commenting that the care their loved one received was of a high standard.

We were pleased to hear that since the last visit, more staff have completed the post graduate qualification in PBS and were committed to creating a more therapeutic, nurturing and less restrictive environment. There remained a concern that the lack of psychology support and supervision would impact on staff's ability to implement PBS.

We were encouraged by the commitment of the leadership team in making improvements to the care and support provided in Islay Centre and Carnethy House. We heard that the CNM and SCN had visited many specialist resources across Scotland and Engand in order to consider other approaches and models of care that would benefit the individuals in the units. We heard and saw that some of these strategies, such as the safety pod, had been implemented to support a therapeutic approach to care and treatment.

Summary of recommendations

Recommendation 1:
Managers should implement a system for the regular audit of care plans to ensure consistency in quality of content, recording and review.

Recommendation 2:
Managers should urgently review the level of medical and psychology provision in the unit, with a particular focus on ensuring parity of provision across the learning disability estate.

Recommendation 3:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, record a clear plan of treatment, and that all psychotropic medication is legally authorised.

Recommendation 4:
Managers and the responsible medical officers must ensure individuals who lack capacity in relation to medical treatment have s47 certificates and where necessary, treatment plans completed in accordance with the AWI code of practice (3rd ed.), to cover all relevant medical treatment the individual is receiving.

Recommendation 5:
Managers should ensure that the need for enhanced observation is clearly recorded, and staff have access to and are conversant with the observation policy.

Recommendation 6:
Manager should ensure that an urgent review of the seclusion policy is undertaken to ensure all seclusion is required, regularly evaluated, and included in the individual's care plan.

Recommendation 7:
Managers must prioritise addressing the outstanding environmental issues in relation to updating fixtures, fittings, decoration, and maintenance issues to make the environment more homely and therapeutic.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report.

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 individual care, treatment and support is 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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk