Mental Welfare Commission for Scotland

Report on announced visit to: North Wing Adult Rehabilitation Ward, Royal Edinburgh Hospital, Edinburgh, EH10 5HF

Date of visit: 30 October 2023

Where we visited

North Wing is a 15-bedded male inpatient rehabilitation unit for individuals between the ages of 18 and 65. Referrals are received from a number of sources, including inpatient acute services, community and forensic services. Many of the individuals referred to North Wing have had contact with mental health services for a prolonged period of time. The objective of the ward is to provide intensive rehabilitation to individuals with complex and enduring mental health needs, with the aim of preparing and supporting individuals with discharge into the community.

The multidisciplinary team (MDT) work closely to provide psychological therapies, psycho-education programmes, and support individuals to develop meaningful activities and strategies to help them through their recovery journey.

During discussion with patients and the staff team, and from reviewing patient files, it was clear that some of the patients in North Wing had reached their rehabilitation potential. For these patients, they have had prolonged periods of inpatient admissions and have been assessed as requiring continuing complex care. We heard that there were limited resources in the community for patients assessed as having continuing complex care needs. We heard that senior managers have recognised the gap in the community service provision for patients with complex care needs and were commissioning a new service to meet this need. At the time of the visit, there were no specific details about the service however, we will continue to monitor developments during future visits to rehabilitation services. We were pleased to hear that there had been five successful discharges from North Wing recently and the new admissions to North Wing were for individuals who met the criteria for rehabilitation.

We last completed a local service visit in May 2016 and made recommendations in relation to the environment, care plans and information regarding the locked door policy. The service was also visited in 2018 as part of the Mental Welfare Commission's themed visit report published in 2020: *Scotland's mental health rehabilitation wards*.

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

Who we met with

We met with, and reviewed the care of six patients, four who we met with in person and six who we reviewed the care notes of. One relative requested to meet with us.

We spoke with the clinical nurse manager (CNM), senior charge nurse (SCN) and members of the nursing team. In addition, we met with the art therapist, occupational therapist (OT) and psychologist.

Following the visit, we made contact with the Volunteering Hub at the hospital.

Commission visitors

Kathleen Liddell, social work officer

Dr Juliet Brock, medical officer

What people told us and what we found

Care, treatment, support and participation

The individuals we met on the day of the visit were positive about their care and treatment in North Wing. The feedback included comments such as, “staff are friendly and helpful”, “I’ve had a good physical and mental health MOT in the ward and feel much better” and “I like that staff make an effort to spend one-to-one time with me”.

They all told us that they had a key nurse who they met with regularly and valued this one-to-one interaction. Individuals reported that all staff made time daily to spend with them on a one-to-one basis and felt this helped them to develop a good and ‘trusting’ working relationship with staff.

All of the individuals we met with told us that they had regular contact with medical staff and their physical and mental health care needs were reviewed. They were aware of their care plan, adding that they had been involved in the compilation of it. All told us that they felt involved in discussion and decision-making regarding their care and treatment, and that they liked the regular contact with advocacy services and contact with the patient council based in the Royal Edinburgh Hospital.

Some of those we met with spoke positively about the activities and outings they had participated in. One had been to see a tribute band in the community and had “the best time”.

We met with one relative/carer. Although they had some issues with one aspect of their relative’s care plan, we were told that they felt able to discuss their concerns with the current team and felt listened too. The relative/carer told us that staff “are very good” and know the patients in North Wing very well. They told us that the staff are good at communicating information with relatives/carers. We also heard that there had been “significant improvements” to the ward environment and staff team in the past year, which they viewed as very positive.

The SCN told us that a carers group was held once a month in the ward and was facilitated by psychology and nursing staff. The carers group provided emotional and practical support and information, as well as an opportunity for carers to meet other carers and staff. There was information regarding the carers group at the front door of the ward to promote attendance at the group.

Care records

Information on individuals’ care and treatment was held electronically on TRAKCare. We found this easy to navigate. The majority of case records were recorded on a pre-populated template with headings relevant to the care and treatment of the patients in North Wing. It was evident from reviewing the case records that individuals in North Wing required high levels of care, motivation and support. The patient group could experience high levels of stress and distress leading to increased clinical risk due to their level of verbal and physical aggression. We were pleased to note that the MDT in North Wing were actively involved in providing the support, care and treatment to patients at these times.

The majority of the care records we reviewed were of a good quality and evidenced person-centred and individualised information, detailing what activities the individual had engaged in that day and what had been positive or challenging. The information in the care records focussed on the strengths of the individuals. For example, we read for one individual that they were kind and compassionate. We were pleased to see comprehensive recordings from all members of the MDT. The records from OT, psychology and art therapy were personalised, outcome and goal focussed and included forward planning. We were impressed with the quality of the majority of the care records and the holistic and recovery-based approach offered to the care of individuals in the ward.

There was evidence of frequent one-to-one interactions between individuals and nursing staff and the consultant psychiatrist. The individuals we met with told us that they met with their key nurse and other members of the MDT regularly. The one-to-one interactions reviewed were comprehensive, personalised and person-centred. There were examples of staff asking individuals their views on their care plan, future planning and discussion of any issues. We were pleased to see that the one-to-one care records also evidenced individuals and staff spending time outside the ward environment and in the community to support rehabilitation goals.

We were pleased to find that the case notes included regular communication with families and relevant professionals.

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. The Commission would expect a rehabilitation service care plan to be based on a whole systems approach with a clear focus on recovery.

We were pleased to find that the information recorded in the care plans was comprehensive, individualised, goal-focussed, person-centred, and adopted a strengths-based, recovery focus and holistic approach. The purpose of the admission was clear and we were pleased to find that where appropriate, the care plans recorded discharge planning and details of communication with community based services to support discharge. There was evidence of the individual's involvement and participation in their care planning and where appropriate, family involvement.

We would expect a rehabilitation care plan to focus on goals around physical, psychosocial, therapeutic, financial, social, recreational, and vocational needs. We were pleased to see that care plans took into account these goals as well as the needs and strengths of the individual. We found examples of individuals asking for support to pursue an interest or develop a skill. For example, we noted that there was support to take part in music lessons. We were pleased to see that staff responded quickly and sought out supports to enable the individual to meet this outcome.

The Commission's themed visit report *Scotland's mental health rehabilitation wards* highlighted the link between long-term mental health problems and an increase of physical health problems. We heard on the day of the visit that many of those in North Wing had been in hospital for prolonged periods of time. Long hospital admissions are known to be a barrier

to routine, something that national health screening patients in the community might otherwise have access to. We were pleased to find that there was a significant focus on physical health care for individuals in North Wing. We saw evidence of input from dietetics and physiotherapy services for patients who required this input.

There was good evidence of physical health care needs being addressed and followed up appropriately by the junior doctor and the recording of physical health care reviews was comprehensive and person-centred.

We saw evidence of a culture that supported healthy lifestyles, particularly in relation to diet, exercise and mental well-being. OT input supported opportunities for individuals to engage in regular exercise and supported them with diet and nutrition. We also saw input from spiritual services for those who had spiritual or religious needs. For individuals who required support with smoking, alcohol and drug addiction, we found evidence of this being offered via smoking cessation and discussion with NHS Lothian addiction services.

We found the risk assessments to be of a high standard and included protective factors and a safety plan. The risk assessment included detailed pass documentation recording the purpose of all time out of the ward and also included a failure to return plan. We found evidence of positive risk taking that supported progress in the individual's care plan.

The care plans were reviewed on a regular basis and we found evidence of meaningful review and patient progress. In addition to fortnightly reviews, we also found that there were three monthly reviews through the Integrated Care Plan (ICP) process. We found comprehensive and detailed information recorded in the ICP. We were pleased to find that the ICP meeting was attended by the MDT, the individual and relative/carer, if appropriate, and reviewed goals on mental health, risk, substance misuse, and time off the ward.

Multidisciplinary team (MDT)

The ward had a broad range of disciplines either based there, or accessible to them. In addition to the nursing staff, there was a full-time consultant psychiatrist, junior doctor, clinical psychologist, psychology assistant, OTs and an art therapist. There was also access to physiotherapy, a dietician, spiritual care and pharmacy. We heard from the CNM that a pharmacy post specifically for rehabilitation services was being recruited to.

We were pleased to hear that the ward had a consistent group of staff who provided care and treatment to patients in North Wing. On the day of the visit, we were told that there were no vacancies and the use of bank staff was rare, used mainly to cover staff holidays and sickness. We heard that due to North Wing being fully staffed most days, staff could be moved to other wards in the hospital. This could negatively impact on patient care as some planned activities, especially in the community, could potentially be cancelled at short notice. We were however pleased to hear from the SCN that if a planned community activity had been arranged for patients, staff would not be moved in order to allow the outing to take place.

We met with the art therapist who told us that there was regular art therapy input into North Wing during the week. Art therapy was offered to individuals on both a group and one-to-one basis. We heard that the focus of the group work was supporting individuals to manage issues they found difficult in the ward, for example, communicating their feelings and how to build

relationships with others. Art therapy offered participants a space to think about their feelings and use art to express their emotions.

We also met with psychology staff and were told that psychology offered group and one-to-one work with individuals in North Wing. Psychology staff completed assessments and formulations. We reviewed some of the formulations and found them to be of a high standard. Psychology staff offered reflective practice to the nursing team.

The MDT met weekly in the ward. The individuals were split into two groups and each group was discussed at the MDT meeting on a fortnightly basis. Individuals were invited to attend their MDT meeting. Nursing staff discussed during their one-to-one interventions the individual's views on their care plan, and if there were issues they wanted to raise in the meeting. On review of the care records and from speaking with individuals, we saw evidence of their, and where appropriate, their family's participation in the MDT meeting recording.

The MDT meeting was recorded on a structured MDT meeting template. We found detailed recording of the MDT discussion, decisions and personalised care planning. We were pleased to see clear links between MDT discussions and the care plan outcomes, as well as evidence that individuals were making progress and moving towards achieving the aims and goals of the admission. It was clear that the MDT was fully involved in the care of patients in North Wing and committed to adopting a holistic approach to the individuals care and treatment. We saw that where discharge planning was progressing, the Community Rehabilitation Team (CRT) was involved to support discharge.

Use of mental health and incapacity legislation

On the day of our visit, 14 individuals were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). One individual was subject to the Adults with Incapacity (Scotland) Act 2000 (the AWI Act). We found the detention certificates relating to the Mental Health Act stored electronically on TRAKCare.

On the day of the visit, we found that the individual who was subject to AWI Act legislation did not have documented details of welfare proxies and the powers granted in the welfare guardianship. Although it was evident that staff were aware there was a welfare guardianship order in place. We raised this with the SCN and responsible medical officer (RMO) on the day of the visit and were disappointed that this documentation was not available. We had concerns that without this documentation, staff caring for the patient would not be aware of the powers granted to the welfare proxy. The SCN and RMO agreed and told us that they would take immediate action on this matter. We were informed by the RMO the following day that the welfare guardianship order and the powers were uploaded onto TRAKCare system.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a named person had been nominated, we found copies of this in the care record.

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 (such as artificial

nutrition) and the authorisation of psychotropic 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 certificate if the patient is consenting.

Medication was recorded on the hospital electronic prescribing and medication administration (HEPMA) system. T2 and T3 certificates authorising treatment were stored separately on TRAKCare. It is a common finding on our visits that navigating both electronic systems simultaneously can be a practical challenge for staff. This is potentially problematic, as it can reduce the ease of checking the correct legal authority is in place when prescribing or dispensing treatment for those who are detained. For this reason we suggested to the ward that a paper copy of all T2 and T3 certificates be kept in the ward dispensary, so that nursing and medical staff have easy access to, and an opportunity to review, all T2 and T3 certificates. The SCN agreed that a paper copy of all T2 and T3 certificates would be compiled and stored in the dispensary.

On cross-checking the electronic records, there was a T2 or T3 certificate in place for all those who required them. The T2 and T3 certificates we reviewed were up-to-date and recorded authorisation of all prescribed treatment.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the AWI Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We found evidence of s47 certificates for patients who required one. For two individuals, there was no treatment plan attached to their s47 certificate. We raised this with the SCN on the day of the visit. Immediate action was taken and treatment plans completed by the end of the visit.

Recommendation 1:
Managers should put a system in place to ensure that when a welfare proxy is in place for a patient, a copy of the document stating the powers of the proxy is held within the care records.

Rights and restrictions

North Wing continues to operate a locked door, commensurate with the level of risk identified with the patient group.

The individuals we met with during our visit had a mixed understanding of their rights and detained status, where they were subject to detention under the Mental Health Act. All of those we met with were aware of their right to advocacy support and some had legal representation. We were pleased to see information sent to them by their RMO detailing their legal status, their rights in relation to this, and contact numbers for advocacy to support exercising of their rights. We noted that ICP meetings also reviewed patient rights. We discussed with the SCN and CNM that given that the individuals we met with had a mixed understanding of their detained status and rights, increased promotion and review of patients' rights would be beneficial. We suggested that a discussion on rights could be incorporated into the fortnightly

MDT meeting. The SCN and CNM agreed and advised that they would take this suggestion forward.

Individuals we met with told us that there was a community meeting in the ward every week organised by nursing staff. The meeting was an opportunity for individuals to communicate their views on any issues in the ward and discuss these with each other and staff. The community meeting also provided an opportunity for participants to make suggestions regarding activities and/or social events they would like arranged in the ward. If individuals did not feel able to make suggestions in a group setting, there was also a suggestion box in one of the communal areas.

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 an individual is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. One individual was specified on the day of the visit. We were unable to locate the paperwork on the day of the visit. We raised this with the SCN and RMO and were told that this had been completed however, it was not stored on TRAKCare when we reviewed the patients care records.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

When we are reviewing patients' files we look 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. Health boards have a responsibility for promoting advance statements. On the day of the visit one individual had an advance statement in their file. From discussion with individuals and the review of ICP documentation, we found evidence that advance statements had been discussed and support offered to complete them. Some of those we met with told us that they had chosen not to complete an advance statement. For others, it was evident during review of the patient files, and during discussion with some of them, that they were not at a point in their recovery to be able to make decisions regarding their future care and treatment.

Advocacy services were available in the ward and provided by the local service, AdvoCard. We were told that advocacy attended the ward on request and provided a good service to individuals who wished to engage with them. We were pleased that all of those we met with on the day either had involvement with advocacy or were aware they could be referred for advocacy support if they wished.

The Royal Edinburgh Hospital had a patient council group that offers collective advocacy and drop-in sessions. We heard that some of the individuals in North Wing had regular contact with the patient council.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that patients 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 2:
Managers should ensure specified persons procedures are correctly authorised for patients where there is requirement to implement restrictions.

Activity and occupation

We heard and found evidence of a broad range of activities that were available for individuals in North Wing. The SCN told us that activity and occupation in the ward was provided by all staff members. This arrangement supported a shared MDT responsibility for providing activity and promoted individuals having regular access to activities and occupation by all disciplines. Nevertheless, it was evident from review of the care records that if there was a need for specific input from members of the MDT such as OT, psychology or art therapy to meet a care goal, we saw individualised involvement from these members of the MDT. The individuals we met, spoke very positively and were complimentary about the activities offered in the ward and out in the community.

There was an activities board in a communal area of the ward that provided information on activities available in North Wing. The activities available included breakfast group, therapet, smoothie group, arts and crafts, mindfulness groups, creative writing, t-shirt painting, football group, music jam, pilates, karate and karaoke. We were pleased to see that individuals could also access activities out with the ward, some of these being provided by third sector providers and the Volunteering Hub. These activities included The Hive, where individuals could engage in activities and socialise with others in the hospital. Some individuals attended the Glasshouses for gardening activities with support provided by the Cyrenians and Artlink. We heard that the volunteers attended the ward regularly and offered activities such as art, poetry and literature discussion, playing chess, and had supported an individual to volunteer in the hospital library.

We met with an OT manager on the day of the visit who told us that OT staff offered a range of group and individual interventions to those in North Wing. We heard that for patients who required OT involvement, an initial screening assessment was completed which informed OT intervention required. We heard that OTs promoted therapeutic interventions with a focus on getting individuals out into nature, either one-to-one or in groups. We heard about the 'Branching Out' initiative which promoted the exploration of natures in and around the grounds of the hospital site.

We also saw and heard that individuals were offered activities to enhance daily living skills. Individuals were supported to deep clean their room regularly with the support of staff. There were set days for laundry and individuals were supported to launder their own clothes. For some, cooking their own meals in the kitchen with the support of staff was part of their care plan. For those who engaged in the cooking programme, a weekly food budget was provided by the ward to purchase food.

We heard that group activities across the rehabilitation service were organised in the community. These activities were based on individual interest and feedback. Individuals we met with spoke very positively about these outings.

The physical environment

North Wing was located on the first floor of the original part of the Royal Edinburgh Hospital. On entering the ward, there was an 'information station' as the SCN told us that relatives/carers tended to congregate at this area. We were impressed with the information available to carers/relatives, mainly in relation to information on the ward, groups available for individuals and carers/relatives and information in relation to staffing.

The layout of the ward consisted of single rooms and double rooms. The individuals we spoke with who shared rooms, told us that they were happy with this arrangement. There were shared toilets, showers and one bathroom. On the day of the visit, we were able to see the double rooms and had concerns about the lack of privacy. The SCN told us that funding had been agreed for renovation work to start imminently. The renovation work will include the fitting of secure partitions between bed spaces. This work will support an increased level of privacy and dignity for individuals. In the meantime, efforts had been made to ensure greater levels of privacy such as fitting privacy film on the bedroom door windows.

We were able to view a single and double room. The condition of the rooms varied. Some rooms were personalised, clean and tidy. Others were untidy with personal items evident on the floor and bed space. The SCN told us that staff encouraged individuals to clean and tidy their rooms daily. Some required support from staff to increase their level of motivation and supervision to undertake this task. We heard that each patient had a deep clean of their room once a week to ensure the environment was of an appropriate standard of cleanliness.

The walls had artwork displayed, some of which had been completed by patients. This promoted a homely and welcoming environment. The ward environment was clean and calm. We were impressed by the autumnal themed art in the ward, especially the notice board that was situated next to one of communal areas. This displayed information, such as the date and time of the community meeting and some 'fun' facts and quotes for individuals to enjoy.

We saw the 'Zen Den', a quiet room to participate in arts and crafts, reading, or to have some quiet time. The room had some information and artwork on the walls including a display on '10 Keys to happier living'. This was to promote mindfulness to those who used the room. We were pleased to see that individuals were actively involved in choosing the name and décor for the room and that the room was used regularly.

We heard from staff, individuals and carers that there had been significant improvements to the environment in North Wing. We saw that many areas of the ward had been renovated and decorated and were particularly impressed with the new kitchen in the communal dining area. Some of those we met with told us that they liked the new kitchen area, and it promoted them to use it to prepare snacks and drinks independently.

We also saw that the environment had been painted and new flooring had been fitted in many of the rooms. We heard that further renovations were planned to take place in the ward. The SCN told us that one of the largest rooms in the ward was being used as a staff base. A decision had been made to use this room and develop a 'multi-purpose' room for patients. The SCN told us that the room will provide a therapeutic space for when de-escalation of stress and distress is required. The room will also be used for games and activities.

We heard that a no smoking policy had been implemented in North Wing. We were told that individuals who smoked had been offered support in terms of nicotine replacement and input from smoking cessation services. We heard that for one individual, smoking in the ward remained problematic. We were pleased to see that the MDT had developed a care plan to support the individual to manage this issue.

The Commission has made recommendations following all visits to the rehabilitation wards in the Royal Edinburgh Hospital in relation to the provision of outdoor space and garden areas. We were disappointed to see that there had been no progress on implementing this recommendation. Although we recognise the location of North Wing makes it difficult to provide outdoor space, the lack of access to outdoor space continues to concern us. We consider access to this as important, especially for individuals who are experiencing stress and distress. From conversations with individuals and staff in rehabilitation wards, there was a clear consensus that access to garden space during times of stress and distress would help manage some behaviours more therapeutically, as opposed to using other interventions, such as medication.

Although individuals did not raise any issues regarding the environment on this visit, there were evident disadvantages for those in North Wing in comparison to other individuals in the new part of the hospital building. We were concerned that individuals' right to privacy and dignity, which is protected by Article 8 of the European Convention on Human Rights, were being compromised due to the environmental factors. We are aware that plans for a new build as part of the Royal Edinburgh Hospital redevelopment project were in place, however this work is some years away and had been further delayed by the Covid-19 pandemic.

Recommendation 3:
Managers should consider ways to achieve parity in relation to the ward environment, garden access, privacy and dignity for all patients in the Royal Edinburgh Hospital.

Any other comments

Throughout the visit we saw kind and caring interactions between staff and individuals, with high levels of staff involvement, either on a one-to-one basis or in a group setting. The atmosphere on the ward was calm and welcoming. Staff we spoke with knew the patient group well and appeared committed and motivated to support rehabilitation. It was positive to note that the individuals and the carer/relative we met with, spoke highly of the care and support provided by the MDT.

We met with many members of the MDT and there was a theme we heard that each profession felt respected and supported by other members of the MDT. All staff spoke positively about the leadership and support provided to them by the SCN. Staff told us that the SCN had made positive changes to the culture of the ward which had created a "cohesive" MDT and increased staff morale and a positive work ethic. All staff spoken with told us that they were happy working in North Wing and felt supported to undertake their role whilst also being encouraged to develop their knowledge and skills. We spoke to staff who had been supported to complete their nursing qualification and valued the belief that the SCN had in them to make this professional transition.

We were particularly impressed by the SCN's communication and organisational skills. We heard and saw that the SCN was committed to creating an environment in the ward that delivered good quality patient care and supported the MDT to carry out their role. We were pleased to see that proactive efforts made by the SCN and management team had created a more comfortable, therapeutic and much improved environment.

The term 'hopefulness' was used by many members of the MDT to describe the SCN and RMO's approach to patient care. We heard that the approach to all individuals in North Wing, including longer term ones who had reached their rehabilitation potential, was holistic and personalised, with a focus on progress and recovery to support moving on from hospital.

Summary of recommendations

Recommendation 1:
Managers should put a system in place to ensure that when a welfare proxy is in place for a patient, a copy of the document stating the powers of the proxy is held within the care records.

Recommendation 2:
Managers should ensure specified persons procedures are correctly authorised for patients where there is requirement to implement restrictions.

Recommendation 3:
Managers should consider ways to achieve parity in relation to the ward environment, garden access, privacy and dignity for all patients in the Royal Edinburgh Hospital.

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.

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