Mental Welfare Commission for Scotland

Report on announced visit to:
The Royal Edinburgh Hospital, Hermitage Ward, Morningside Place, Edinburgh, EH10 5HP

Date of visit: 12 August 2024

Where we visited

Hermitage Ward is the mixed-sex adult acute psychiatric admission ward for individuals primarily residing in East and Mid Lothian areas of NHS Lothian. We heard that the majority of beds are used by East and Mid Lothian individuals. However, some of the beds are occupied by City of Edinburgh individuals for a variety of reasons; mainly patient preference of not wanting to be an inpatient in a single-sex ward and/or resulting from risk assessment.

Hermitage Ward has 16 beds and on the day of the visit there were 17 individuals in the ward. We were told that six individuals were boarding from other adult acute or rehabilitation wards in the Royal Edinburgh Hospital (REH).

We last visited this service in August 2023 and made recommendations in relation to rights-based care, activities and the use of the quiet room as a bedroom.

On the day of this visit we wanted to meet with individuals and relatives/carers to hear how care and treatment was being provided on the ward and also follow up on the previous recommendations.

Who we met with

We met with, and reviewed the care of eight people, seven who we met with in person and eight who we reviewed the care records of. We also spoke with one relative.

We spoke with the clinical nurse manager (CNM), senior charge nurse (SCN), nursing staff and practice development and improvement nurse.

Following the visit, we made contact with the music therapist and mental health officer teams from East and Mid Lothian.

Commission visitors

Kathleen Liddell, social work officer

Susan Tait, nursing officer

Denise McLellan, nursing officer

What people told us and what we found

Comments from individuals

The majority of the individuals we met with on the day of the visit provided positive feedback about their care and treatment in Hermitage Ward. We heard that staff were “patient”, and “approachable and supportive”. We heard from most individuals that staff offered them regular one-to-one support which they valued and benefitted from.

Some individuals commented that staff were “very busy” however they made “every effort” to ensure they took time to “check in” on individuals which made them feel safe on the ward.

Most of those that we spoke with felt involved in decision-making about their care and treatment. We heard from some individuals who were subject to detention that they did not always agree with aspects of their care and treatment, although they felt that all members of the multidisciplinary team (MDT) took time to discuss and explain decisions made which informed their care and treatment.

Not all individuals that we met with were aware of their care plan and some reported that they had not participated in care planning. We were told that most individuals were invited to attend the weekly MDT ward meeting and met with their consultant psychiatrist weekly. We were told that for individuals who were boarding in the ward, they did not attend a weekly MDT meeting and instead were ‘reviewed’ by their consultant psychiatrist.

All that we spoke with were aware of their rights and had access to either advocacy and/or legal representation. We heard from many of the individuals that we spoke with that they had been supported to exercise their rights.

Some individuals provided feedback on aspects of the environment, telling us that it would benefit from upgrading. We heard that the chairs in the communal area were uncomfortable to sit on and individuals said that the ward would benefit from more comfortable furnishings.

All individuals told us that there was not much structured activity organised on the ward, resulting in long periods of time with “nothing to do”. We heard that most activity was provided out with the ward at the Hive, which was not a suitable option for all individuals, as they either did not feel well enough or did not have the motivation to leave the ward. One individual commented that they tended to lie longer in bed as “there was nothing to get up for”.

Comments from relatives

We spoke with one relative who provided positive feedback on the care and treatment of their loved one. We were told that that the care provided was “very good” and that staff communicated well with relatives, regularly asking for their views which helped them feeling involved in decisions regarding care and treatment. We heard that when their loved one was on pass, ward staff regularly made contact with the individual and their family to offer support and guidance; the relative felt that was beneficial.

We heard and saw that the ward has a carers group that runs every month when carers could attend.

Comments from staff

We talked to staff who commented that they felt “happy and supported” in their role. We heard from all staff that the level of acuity and complexity in the ward had increased and that there were longer periods of high acuity in the ward; this was demanding for staff. We were told that the team were short staffed which was challenging, although the team were pleased that new staff would be joining them in September 2024.

We heard that staff felt supported by the ward management team and there was good leadership from the SCN.

Care, treatment, support and participation

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.

We found the care plans in Hermitage Ward to be of mixed quality. We were disappointed to find that the quality in many of the care plans we reviewed had deteriorated since the last visit.

We found the majority of care plans to be didactic, with little evidence of person-centred aims and goals recorded. There was limited evidence of information being gathered from the initial nursing assessment to support personalised care and suitable interventions. We did not find information recorded on required interventions and the goals were not based around SMART (specific, measurable achievable, relevant, timebound). This made it difficult to ascertain how care goals would be met, who was responsible for providing the intervention and how the individual’s participation would be promoted.

We heard from some individuals that they did not have any knowledge of their care plan. It was evident from review of a number of care plans that participation from the individual was not reflected in the care record. This raised concerns that the principle

of participation was not being actively used to encourage and allow individuals to be involved in decisions about their care.

Recommendation 1:
Managers should ensure that there is a system in place for all individuals that is understood and offer them an opportunity to engage in meaningful participation in care planning and decisions about their care and treatment. The participation of the individual should be recorded in their clinical record.

We were pleased to find that some of the care plans we reviewed were individualised, person-centred, goal and outcomes focussed and had recorded detailed interventions. These care plans included information on what and who was important to individual, how they preferred to be communicated with and the support they needed from staff and what interventions did and did not support meeting their care goal.

Where appropriate, we found that families had had some involvement in the care plan and had provided information from their perspective as a relative/carer of the individual.

We saw that physical health care needs were being addressed and followed up by the junior doctors. However, we were concerned to hear that there were periods of time when there was no junior medical cover in the ward. We heard about a lack of medical cover was evident when junior doctors were 'changing over' and no alternative arrangements were put in place to ensure availability of medical staff. We heard that the SCN had escalated concerns to senior NHS managers, and we will follow this up on the next visit.

We found most risk assessments to be comprehensive and of a good standard. The risks were clearly recorded with a plan to manage each identified risk. We found regular review of the risk assessments and evidence of changes made to the risk assessment following review depending on the individual's progress or new/increased risk.

We also found that care plans were reviewed regularly although the quality of the review process was mixed. We found some good examples where robust information included a summative evaluation regarding the efficacy of intervention, where there was a targeted nursing intervention, as well as the individuals' progress. These reviews included detailed discharge planning and discussion with community teams to support discharge. However, other reviews did not include this level of information and it was difficult to evidence if the individual was making progress towards their admission aims, objectives and care goals.

We discussed the mixed quality of the care plans and reviews with the SCN and the practice development and improvement nurse on the day of the visit. We were

encouraged to hear that managers were aware that improvements to care planning were essential and that work was being underway to make improvements. We were told that a new care plan tool would be available to use by the end of 2024 and that all staff will undergo training on care plans and risk assessment.

Recommendation 2:
Managers must ensure nursing care plans are person-centred, contain individualised information reflecting the care needs of each person, identify clear interventions and care goals, include a summative evaluation indicating the effectiveness the interventions being carried out and any changes required to meet care goals.

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

Care records
Information on individuals care and treatment was held electronically on TrakCare; we found this easy to navigate.

The information recorded in care records was of mainly of a good quality. We found that where staff used the canned text, a pre-populated document with headings relevant to the care needs of individuals in Hermitage Ward, the care records were detailed, strengths-based, personalised and intervention focussed.

We were pleased to see that all members of the MDT recorded in care records and found detailed examples from psychology and occupational therapy (OT) of comprehensive documentation that promoted a holistic approach to the individual's care. We were pleased to see regular and comprehensive reviews of individuals by the consultant psychiatrists.

We did not find this same level of detail in care records where canned text was not used. We found the use of some language that was recorded in the care records such as "evident on the ward" and "keeping a low profile" was commonly used in practice when we have done visits to NHS Lothian. We do not find this language gives an acceptable level of detail on the individual's current circumstances or interventions provided by staff.

We would prefer consistency with the MDT recordings in care records to ensure they contain person-centred and personalised information. We were encouraged to hear from the practice development and improvement nurse that audits had been completed on care records which highlighted areas of improvement needed. We

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

were told that training and support will be provided to staff to help them improve the recording of care records.

We saw evidence of regular one-to-one interventions between nursing staff and individuals that reflected what individuals told to us. The information recorded in these interventions was person-centred and strengths-based and included discussions regarding the individual's views on their care and treatment plan.

We were pleased to find communication with families and relevant professionals recorded in the care records.

We saw that for individuals where discharge was imminent, community mental health teams had been contacted and discussions regarding discharge planning had taken place.

It was evident from reviewing the care records that there were high levels of clinical acuity in Hermitage Ward. Individuals in the ward could experience high levels of stress and distress leading to increased clinical risks associated with verbal and physical aggression, and self-harm. We were pleased to note that the MDT were actively involved in providing the support, care and treatment to individuals at these times.

Multidisciplinary team (MDT)
The unit had a broad range of disciplines either based in Hermitage Ward or accessible to them.

In addition to nursing staff, there were consultant psychiatrists, psychology, OT, a recreational nurse, junior doctor and music therapist. The structure of the MDT in Hermitage differed from the other acute wards in the REH, as it covered two Health and Social Care Partnerships (HSCPs) as well as City of Edinburgh area. Since our last visit, there had been a reduction in one consultant psychiatrist for Mid Lothian. Consultant psychiatrist cover was being provided by ST6 doctors with oversight from the substantive consultant psychiatrist. We were told that recruitment for a new consultant psychiatrist was being progressed. East Lothian continued to have two consultant psychiatrists, and each held weekly MDT meetings on the ward.

The MDT ward round for East and Mid Lothian individuals was recorded on TrakCare. The MDT meetings we reviewed were recorded on a mental health structured MDT meeting template; the template had headings relevant to the care and treatment being offered in the ward.

We found that these records were comprehensive and contained detailed recording of the MDT discussion and decisions. We saw evidence of detailed psychology formulations in some of the individuals' files we reviewed.

We were pleased to find that some individuals had attended the MDT meeting and provided their views on various aspects of their care and treatment.

The relative/carer we spoke to told us that they were aware of the weekly MDT meetings however could not always attend due to work commitments. They added that they were consulted about decisions made and given an opportunity to provide their views.

We were concerned to see and hear that for individuals boarding in Hermitage Ward, there was no weekly MDT meeting; they were reviewed by their consultant psychiatrist on a weekly basis. The review did not include input from the MDT and was not recorded on the mental health structured MDT meeting template. We were concerned that unilateral decisions made by the consultant psychiatrist did not support MDT discussion or decision-making and was not conducive to a holistic approach to the individuals care and treatment. We heard from one individual that their consultant psychiatrist attended the ward without prior notice, resulting in them not having an opportunity to arrange required advocacy support. We discussed this lack of parity for individuals boarding in Hermitage Ward with SCN on the day of the visit. We suggested the service review the current arrangement and consider alternatives that will support a full MDT approach to discussion and decision-making for all individuals in Hermitage Ward. We will follow this matter up at the next visit.

We contacted the East and Mid Lothian SW/MHO Teams for feedback on their experience of engagement with Hermitage Ward. We were pleased to be told that there were positive working relationships between the services. Social work commented on the work pressures on nursing staff and the impact that this could have on communication. We heard that on some occasions, the individual's discharge did not reflect the discharge plan and social work staff were only made aware of the discharge after the event. On these occasions, social work had raised their concerns with the service.

Use of mental health and incapacity legislation

On the day of the visit, 13 people 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 informal and detained status where they were subject to detention under the Mental Health Act. The files we reviewed evidenced involvement of legal representation and advocacy to support their understanding of legal status and exercising of rights.

All documentation relating to the Mental Health Act was stored electronically on TrakCare and easily located.

Part 16 (sections 235 to 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 certificate 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. We found that for one individual who was consenting to treatment, the T2 certificate had not been completed. We raised this with the SCN who advised that the RMO would be made aware of this matter urgently.

We also found two individuals who had medication prescribed which was not authorised by the T3 certificates. We highlighted this issue on the day of the visit and were assured by the SCN that an urgent review of the T3 certificates would be undertaken and individuals would be made aware of the unauthorised treatment and their rights in relation to this.

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

Medication was recorded on the hospital electronic prescribing and medication administration system 'HEPMA'. 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 during the visit 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 to arrange a folder containing paper copies of all T2 and T3 certificates following the visit.

Any patient 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 patient had nominated a named person, we found this stored on TrakCare.

Rights and restrictions

Hermitage Ward continued to operate a locked door, commensurate with the level of risk identified with the patient group. The ward had a locked door policy that was displayed at the entrance door.

We made a recommendation in the previous report in relation to improved rights-based care being delivered and information on rights being visible throughout the ward. We were pleased to find significant improvements had been made to support a proactive approach to the delivery of rights-based care.

We noted that there was a range of information on rights displayed and available to individuals in Hermitage Ward. In particular, we found the information board displayed at the entrance of the ward provided excellent information on the Mental Health Act, criteria for various mental health orders, individuals rights when subject to orders and how to exercise their rights. As well as written information, the information board included QR codes to the Commission's website, to support the individual getting access to further rights-based information.

The service had also introduced a 'rights care plan' for individuals in the ward. The care plan included information on legal status, the individuals' rights and how rights could be exercised. We were pleased to see that where restrictions had been put in place, especially with informal individuals, for example escorted pass, the restrictions were discussed with the individual and consent provided and recorded where required. We were encouraged to hear that efforts to promote rights-based care had been effective, as all individuals spoken with were aware of their rights and had support from either Advocacy or a legal representative to support and promote their rights.

One individual was subject to continuous intervention (CI) on the day of the visit. On review of the individuals care records, the use of CI was proportionate to the identified risk. The recording of CI was comprehensive, and we were pleased to see that when appropriate, the use of therapeutic engagement and activity was used by the MDT during CI. We saw regular review of the use of CI by the RMO. The recording by the RMO was comprehensive, with clear evidence of the individual's views.

When we are reviewing patients' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We did not find any advance statement in the individual files we reviewed. We saw from reviews of some individual care records that discussion in relation to advance statements had taken place with the individual choosing not to complete one; other individuals were unaware of advance statements. It was evident from review of the individuals' files

and during discussion with some individuals that they were not at a point in their recovery to be able to make decisions regarding their care and treatment. We were told by the SCN that for individuals who were considering making an advance statement, advocacy was contacted to support the patient in this process.

We were told that advocacy was available regularly in the ward by advocacy services from each HSPC. We were told that advocacy attended the ward on request and provided a good service to individuals who wish to engage with them. We were pleased that all of the individuals we met with on the day of the visit either had or had been offered advocacy support.

The Commission's *Rights in Mind*[2] pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment.

Activity and occupation

When the Commission last visited Hermitage Ward, there had been no recreational nurse in post for a prolonged period. At that time, we heard and found that there were limited structured activities on the ward. This led to individuals commenting that they felt "bored". We were pleased to find that a recreation nurse has since been recruited.

We heard and saw some improvement in opportunities for activity and occupation. Nevertheless, we were disappointed that there was very little regular planned activity organised in the ward. We noted that structured activities mainly took place out with the ward at the HIVE, a day service run by SAMH that is situated in the grounds of the REH. Although the feedback from individuals who attended The HIVE was positive, this arrangement was problematic for some individuals as time off the ward was dependent on risk assessment and pass planning.

We were encouraged to see that there had been improvements to the completion of activity care plans for some individuals, although we would have preferred all individuals to have an activity care plan in place. The activity care plans we reviewed provided information on the activity and occupation that was required to meet an individual's care goal. We found that the care plan goals did not align with information recorded in the care records. We discussed our concerns with the SCN, noting that limited progress had been made in providing individuals with access to regular activities to maximise therapeutic benefits, improve mental well-being and reduce stress and distress. The SCN agreed with the concerns raised, reporting that regular periods of staff absence had had a detrimental impact on the consistency of

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

activity being offered. The SCN agreed that that current arrangement for providing activity required review.

We were aware that OT were involved with many individuals in Hermitage Ward. We saw from our review of the care records that initial and functional assessments completed by the OT had informed the care goals and interventions that were required. We were pleased to see skill development opportunities being provided to some individuals which supported future and discharge planning.

Music therapy was available in Hermitage Ward. We heard that the music therapist offered a weekly open music psychotherapy group and two individual sessions, although music therapy had temporarily ceased to allow a change in music therapist. We were provided assurances that this therapy would start again imminently.

We heard that there had been a reduction in the amount of volunteer input to Hermitage Ward. While we were pleased to hear that a volunteer continued to attend the ward to provide therapet support, we were aware that clay modelling had stopped. The Commission are aware of the recent changes made to the provision of volunteer support across the REH. We were concerned that for Hermitage Ward, the changes had not been beneficial and increased volunteer input would provide additional opportunities to engage in skills based and therapeutic activity. We are therefore repeating our recommendation from our last visit.

Recommendation 4:
Managers must ensure that there are structured activities regularly available to individuals that have a therapeutic and well-being focus. Managers should ensure that activity participation is recorded and evaluated.

The physical environment

Hermitage Ward is the only mixed-sex admission ward in the REH, therefore the physical environment has to be managed differently from other admission wards in the hospital, to ensure individuals feel safe and comfortable in the ward setting. The bedroom zones in the ward were divided into a male and female area. Each bedroom has en-suite facilities, and we were aware that individuals could personalise their room if they chose to.

The cleanliness of the ward was of a high standard. The main space used by individuals and staff was an open plan, communal TV/dining area. This area would have benefitted from the addition of some artwork and soft furnishings to support a more homely, and less clinical, environment. Individuals commented that the chairs in the communal area which were used to watch TV were uncomfortable and they would have preferred comfortable seating to be provided.

In our previous report, we made a recommendation in relation to concerns over the use of one of the quiet rooms in the ward.

A 'contingency bed' was being kept in one of the quiet rooms and was being used as a bedroom. We were disappointed to be told that the quiet room has continued to be used regularly as a bedroom since our last visit. We saw this again on the day of the visit. We raised our concerns with the senior management team that the room did not have washing or toilet facilities and compromised the individual's right to privacy and dignity. Although we are aware of the national shortage of mental health beds, we do not consider this room appropriate or safe as patient bedroom. Furthermore, we were concerned that by using this space as bedroom, it limited the therapeutic and quiet space available on the ward for other individuals to use.

Recommendation 5:
Managers must consider the benefits of returning the dedicated quiet room in the ward to provide a therapeutic and quiet space for individuals and staff.

We were told by some individuals that the ward environment was often busy and loud, and it was difficult to find quieter areas in the ward. We are of the view that individuals benefit from having a quiet and therapeutic space to use.

There was a large courtyard garden area that was easy for individuals to access. We were told that individuals could access the garden area from 6am until midnight. We saw during the visit that this area of the ward was regularly used by individuals.

However, on the day of the visit we saw evidence of individuals smoking in the courtyard. We saw signage on the doors leading to the courtyard and throughout the ward asking individuals to refrain from smoking, as well as educational information on risks of smoking. Individuals and staff that we spoke with reported that it had been difficult to support the implementation of the current legislation around the smoking ban.

We are aware of the challenges for individuals not being able to smoke, which for many was against their views and wishes. We heard from staff about a recent incident in the ward where a staff member had been seriously assaulted when asking an individual to refrain from smoking. This incident had understandably caused staff anxiety when challenging smoking in the ward environment. It is important that staff are supported by senior NHS Lothian managers to enable implementation of the current legislation. We heard that a date had been set to implement the smoking ban across the hospital site. We were told that in preparation for the ban being implemented, there was regular contact with smoking cessation and community mental health teams to promote support and information to individuals on the smoking ban.

Any other comments

The feedback from individuals and the relative spoken with about the care and treatment in Hermitage Ward was positive. We saw evidence of good care during the visit that supported this feedback.

We noted the considerable efforts made by the team to promote the delivery of rights-based care to individuals and empower people to have information on rights and being offered support to exercise their rights. It was clear on the day of the visit that these efforts had been effective as individuals were aware of their rights had has been supported to exercise them.

Staff spoken with had an awareness of the ongoing areas of improvement needed and were transparent about the barriers to progress. This level of awareness and transparency demonstrated an ongoing commitment by the leadership team to prioritise identified areas of improvement in order to provide high quality care and treatment to individuals in Hermitage Ward.

Summary of recommendations

Recommendation 1:
Managers should ensure that there is a system in place for all individuals that is understood and offer them an opportunity to engage in meaningful participation in care planning and decisions about their care and treatment. The participation of the individual should be recorded in their clinical records.

Recommendation 2:
Managers must ensure nursing care plans are person-centred, contain individualised information reflecting the care needs of each person, identify clear interventions and care goals, include a summative evaluation indicating the effectiveness the interventions being carried out and any changes required to meet care goals.

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

Recommendation 4:
Managers must ensure that there are structured activities regularly available to individuals that have a therapeutic and well-being focus. Managers should ensure that activity participation is recorded and evaluated.

Recommendation 5:
Managers must consider the benefits of returning the dedicated quiet room in the ward to provide a therapeutic and quiet space for individuals and staff.

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 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