Mental Welfare Commission for Scotland

Report on announced visit to:
Royal Edinburgh Hospital, Merchiston Ward, Morningside Place, Edinburgh, EH10 5HF

Date of visit: 9 September 2024

Where we visited

Merchiston Ward is a 16-bedded, male adult acute admission ward with a catchment area for the southwest and southeast areas of Edinburgh. On the day of the visit, the bed capacity had been increased to 17 beds with the use of one contingency bed, located in the quiet room. We were told that some individuals who met the criteria for the ward were boarding in other acute wards across the hospital site, due to no bed capacity in Merchiston Ward.

We last visited this service in November 2019 and made recommendations on developing a single shared system to store individuals' information, ensuring an audit system was in place to review care plans, ensure staff are aware of seclusion and risk assessment policies, provide opportunities for individuals to devise and engage in activities and to create a smoke free and therapeutic environment.

On the day of this visit, we wanted to follow up on the previous recommendations. We also wanted to meet with individuals, relatives/carers and staff to hear their views and experiences on how care and treatment was being provided on Merchiston Ward.

Who we met with

We met with, and reviewed the care of six people, two who we met with in person and six who we reviewed the care notes of. We also spoke with one relative.

We spoke with the clinical nurse manager (CNM), charge nurse (CN), art psychotherapist team lead, nursing staff and recreational nurse.

Commission visitors

Kathleen Liddell, social work officer

Gillian Gibson, nursing officer

What people told us and what we found

Comments from individuals

The individuals we met on the day of the visit provided mixed feedback about their care and treatment in Merchiston Ward. We heard from most individuals that staff were “nice” and that individuals had a named nursed that they could approach if they needed support. We heard that one-to-one support was offered to individuals and beneficial however, it tended to be the individual who instigated contact with nursing staff, as we heard that staff were busy. We heard that individuals had regular contact with consultant psychiatrists and medical staff which they viewed as positive.

None of the individual’s we spoke with were aware of their care plan, nor had they participated in the completion of it. We heard differing views regarding involvement in discussion and decision-making regarding care and treatment. One individual told us that they attended their weekly ward meeting and provided their views to the multi-disciplinary team (MDT). The other individual we spoke with told us that they were not invited to attend this meeting and did not feel they were given the opportunity to provide their views and be involved in decision-making regarding their care, support and treatment.

Recommendation 1:
Managers should ensure that there is a system in place for all individuals that is understood and offers 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 care records.

Both individuals we met with were aware of their rights and had legal representation and support from advocacy services to enable them to exercise their rights.

We heard that at times individuals felt ‘bored’ and that there were no activities available that they enjoyed engaging in. We also heard from individuals that they engaged in ward-based and community activities and particularly enjoyed attended a show at the recent Fringe Festival.

We heard from both individuals that the ward environment could be challenging at times due to the high levels of acuity of the other patients in the ward. We heard that the communal areas could become “loud” and at times “threatening”. We heard that individuals witnessed incidents of verbal and threats of physical aggression towards staff and individuals. We heard from individuals that at these times, they tended to go to their room for “safety” as there was limited space in the ward for them to use during these challenging times.

Comments from relative/carers:

We had a discussion with one relative/carer. They provided positive feedback about the care and treatment their family member was receiving in Merchiston Ward adding that staff were “supportive and engaging” and ‘it was the “best care” their family member had received. The relative/carer told us that the doctors and nursing staff communicated with them on a regular basis and asked them to provide information and their views on their family members care and treatment. We heard that their views on treatment were not always progressed however, they were satisfied that their view was sought and felt listened too.

The relative/carer told us that they felt there was a good level of activity for their family member to engage in and commented on the “good facilities” the ward offered.

We were told that a carers support group ran monthly in the Royal Edinburgh Hospital (REH).

Care, treatment, support and participation

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.

We were pleased to find that the recommendation in the previous report had been progressed and there was now a single system in place for patient information to be stored. We reviewed the care plans that were stored electronically on TRAKCare.

We highlighted in the previous report that information in the care plans was brief and lacked a person-centred approach. We were disappointed to find that limited progress had been made in care planning. The majority of the care plans we reviewed lacked person-centred detail, were mainly didactic, generic and did not evidence strengths-based, goal or outcome focussed interventions.

We did not see consistent involvement from the individual in their care plan. When participation from the individual was evident, we found the care plan to be more person-centred, individualised and strengths-based.

We saw that a comprehensive assessment was completed on admission to Merchiston Ward for some individuals. We were told that the assessment template supported the gathering of information on the individuals’ personal circumstances to ensure a holistic approach to their care and treatment. We reviewed one assessment that provided good quality information on the individual’s circumstances. This information was not reflected in their care plan, as this would have supported a more individualised approach to their care, support and treatment.

We discussed with the CNM and CN that consistent completion of the comprehensive assessment was an opportunity to promote the participation of the individual and could lend itself to promoting person-centred and individualised care, if the appropriate information was recorded alongside the participation of the individual.

We found regular care plan reviews were taking place. Most of the reviews were not comprehensive and did not evidence targeted nursing intervention and individuals' progress. We did find some examples of more robust reviews that indicated a change in support needs which were subsequently reflected in the care plan.

In discussion with CNM and CN on the day of the visit, they acknowledged that improvements to care planning and reviews were required. We were encouraged to hear that a project was underway to develop a new care plan that will be specific to individuals admitted to a mental health ward. We were told that the new care plan was expected to be available on TrakCare by the end of 2024. In addition, we heard that NHS Lothian had recruited three new development officers across the hospital site, one of which will specifically focus on improving the quality of care plans.

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 of 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, which we found easy to navigate.

The care records were recorded on a pre-populated template with headings relevant to the care and treatment in Merchiston Ward. On review of the care records, we found comprehensive and individualised information recorded by all members of the multi-disciplinary team (MDT). The majority of the information recorded was person-centred, strengths-based, outcome and goal focussed and included forward planning. It was evident from reading the care records how the individuals in Merchiston Ward had spent their day, what interventions each member of the MDT had provided and the outcome of interventions. Overall, the care records were of a high standard.

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

We did however find that the language used, such as “evident on the ward” and “keeping a low profile” did not provide helpful information on the individuals’ current circumstances or interventions provided by staff and would prefer care records to contained personalised information.

We saw some one-to-one interactions between individuals and nursing staff recorded in care records however, this was not consistent. The recording of the one-to-one interactions we reviewed were comprehensive and strengths-based. We discussed with the senior management team that promotion of consistent one-to-one interactions instigated by nursing staff was important, as we heard from individuals that they found this intervention positive and beneficial to their recovery.

When reviewing the individuals’ care records, we were pleased to find evidence of comprehensive discharge planning that involved the individual, family members, the MDT, social work and community services.

Care records evidenced regular communication with families and relevant professionals, including community teams.

We found the standard of risk assessments to be variable. Some risk assessments reviewed clearly recorded assessed risk with a plan to manage each identified risk factor. Other risk assessments lacked detailed information of the identified triggers, protective factors and stressors and instead recorded 'unknown at present'. We were concerned that this information had not been updated over the period of the admission given the mental health acuity, the presentation of violence and aggression from many individuals in the ward.

We saw that for some, risk safety plans information was basic and did not provide any evidence on what reduced the risk, what positive risk-taking strategies were in place and robust management of identified risk. We were encouraged to see that the risk assessments were reviewed regularly however, we found that for some individuals, the information in the review did not always reflect the progress or change in risks.

Recommendation 3:
Managers should ensure that all individuals have a risk assessment that records comprehensive information on assessed risk, positive risk-taking strategies, promotion of risk enablement and robust management of identified risk.

We saw that physical health care needs were being addressed and followed up appropriately by junior doctors and the advanced nurse practitioner (ANP) where appropriate. The medical reviews completed by the junior doctors and ANP were of a high standard and included comprehensive information that was personalised and detailed forward planning for care and treatment.

We were pleased to see comprehensive care recording from most members of the MDT. The care records from the music therapist, occupational therapist (OT), physiotherapist, ANP and dietician were personalised, outcome and goal focussed and included forward planning. We were encouraged to see regular and comprehensive reviews of individuals by their consultant psychiatrists.

Multidisciplinary team (MDT)

The ward had a broad range of disciplines either based there or accessible to them. The MDT was made up of three consultant psychiatrists, a specialty doctor, junior doctor, nursing staff, OT, psychology and an art psychotherapist. We found that there was regular input, discussion and liaison from an advanced nurse practitioner to support assessment and review of physical health care needs. Input from pharmacy, physiotherapy, speech and language therapy, and the dietician was also evident in the care records. We were pleased to see regular mental health officer (MHO) and social work involvement in MDT discussions.

It was evident from review of the care records, that all members of the MDT were involved with the care and treatment of the individuals. For many of the individuals we reviewed, the OTs had completed a functional assessment and were engaging regularly with individuals, supporting the assessment outcomes. We saw that OTs were actively supporting discharge and in addition providing some group-based activities out with the ward environment.

The involvement of psychology with the individuals we reviewed, and the recording of their interventions was very detailed, person-centred and recorded a clear plan which set out the level of engagement, the individual's presentation and therapeutic benefit.

We met with the art psychotherapist lead and were told that music therapy had recently ended in Merchiston Ward, and that art therapy would commence. We heard that music and/or art psychotherapy was provided to individuals in addition to clinical psychology input, to support individuals in understanding their diagnosed mental illness, symptoms and to provide support with emotional dysregulation.

We heard that the intervention was provided in ward-based groups to support engagement at the individuals' own pace. One-to-one sessions were also provided to individuals. The MDT discussed referral criteria for this support during daily rapid run-down meetings or at the MDT meetings.

Each consultant psychiatrist dedicated to the ward held weekly MDT meetings. In attendance at these meetings were medical staff, nursing staff and at times, staff from the art psychotherapy teams and psychology.

On review of the MDT meeting paperwork, we found that there was an inconsistency in relation to attendance and involvement of the individual. For some individuals,

they were invited to attend their MDT meeting however, for others they were not. For these individuals, we saw that the consultant psychiatrist met with them weekly to discuss aspects of their care, support and treatment however, the individual was not part of the full MDT discussion and decision-making forum.

We did not find consistent evidence of relatives/carers attending these meetings although we did see communication with relatives/carers and their views were discussed as part of the meeting.

We discussed the importance of promoting the principle of participation and supporting all individuals in Merchiston Ward to participate as fully as possible in any decisions made, with the CNM and CN. They agreed that a review of the current MDT meeting arrangements would be undertaken to consider how the participation of all individuals could be increased.

The MDT meetings we reviewed were recorded on a mental health structured MDT meeting template and held on TrakCare. The template had headings relevant to the care and treatment of the individuals in Merchiston Ward. We found variation in the completion of the structured MDT meeting template. We found some excellent examples of MDT records that were comprehensive and contained detailed recording of the MDT discussion, decisions and planning. Other MDT meeting records lacked this level of detail and did not record staff who attended the meeting or information on discussion, decision making and planning. We raised this with the senior management team on the day of the visit.

We heard that there were some vacancies in the MDT, mainly nursing staff. We heard that there was some use of regular bank staff which promoted consistency of patient care. We were encouraged to hear that three newly qualified Band 5 nursing staff would be joining the team imminently. We were told by staff that the team in Merchiston Ward had a mix of skill, experience and knowledge and that staff knew each other's areas of strengths.

Staff we spoke with told us that they were happy working in the team, they were committed to providing individuals with high quality care and felt supported by their colleagues and managers to undertake their role.

Use of mental health and incapacity legislation

On the day of our visit, nine individuals in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All documentation relating to the Mental Health Act was electronically stored 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 one individual who had medication prescribed that was not authorised by the T3 certificate. We also found that for one individual, they had not consented to medication prescribed under a T2 certificate. We highlighted this issue on the day of the visit and were assured by the CNM that an urgent review of the T2 and T3 certificates would be undertaken.

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.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

From the files we reviewed we found that where necessary, section 47 certificates had been completed, stored on TRAKCare and the detailed interventions and treatment were covered by the s47 certificate. We did not find accompanying treatment plans for all s47 certificates reviewed. We raised with the service that where the individual has multiple healthcare needs authorised under Part 5 of the AWI Act, the use of a treatment plan is recommended.

Rights and restrictions

Merchiston Ward operated a locked door, commensurate with the level of risk identified with the individual group. The ward had a locked door policy that was displayed at the entrance door.

We saw that each detained individual received a letter from medical records following detention under the Mental Health Act that included information on their detained status and their rights in relation to this.

The individuals we met with during our visit had a good understanding of their detained status and of their rights regarding this. From the files we reviewed, there was evidence of legal representation and advocacy involvement to support

individuals understand their legal status and exercise their rights. 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.

We were pleased to hear that the service had been developing the promotion of rights-based care. The CNM told us that there had been contact with another NHS health board to discuss how they promoted rights in acute ward settings. The service had developed QR codes for individuals that provided information on mental health legislation, rights when detained under the Mental Health Act, rights for informal patients and medication information. We discussed with the CNM and CN the importance of staff having regular follow up discussions with individuals regarding rights, to ensure rights-based care was being actively and consistently promoted.

On reviewing the care records, we found that for some individuals who had been admitted on an informal basis, they had restrictions to their pass plans, mainly that these were time limited or escorted passes. We found that in some of the pass plans, they did not record the individuals consent to these restrictions. Other pass plans had not been reviewed or updated following MDT decisions regarding pass.

We discussed this with the CNM and CN and advised that pass plans must record the individual's consent, and provide detailed reasons for the restrictions, including the individual's view and timescales for review of the restrictions.

There was one individual who was subject to continuous intervention (CI). We reviewed the individual's documentation and highlighted that although there was a clear clinical rationale for the requirement of the CI, we suggested that the MDT should review the duration of the CI as we were concerned it was not proportionate to the assessed need or risk. The service agreed to review the CI as a matter of urgency.

When we are reviewing individuals' 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.

During discussion with one individual and in reviewing six care files, we saw one copy of an advance statement. We noted that the advance statement had a medication recorded that the individual was clear they did not want to be prescribed however, they were receiving this medication as part of their current treatment plan.

We could not locate an override of the advance statement to authorise this treatment. We raised this issue with the CN who confirmed that the individual was

consenting to the treatment as documented in the T2 certificate. The CN agreed to raise with the MDT the importance of knowledge of any advance statements, in giving consideration to the information recorded in the advance statement and supporting regular review of it so that it reflected the individual's current wishes and views on their care and treatment.

It was evident from review of the individual files and during discussion with some of the individuals that they were not at a point in their recovery to be able to make decisions regarding their future care and treatment. We discussed the responsibility of the health board in promoting advance statements with the CNM and the CN and made suggestions, such as including advance statement discussion into the MDT meetings, as well as discharge planning discussions.

We were told that advocacy was provided regularly in the ward by the advocacy service, Advocard. Advocacy attended the ward on request and provided a responsive service to individuals who wished to engage with them. Individuals we met with and reviewed 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

Merchiston Ward had a recreational nurse who provided most of the activity in and out of the ward.

We met with the recreational nurse and were told that individuals were offered the opportunity to meet with them on admission to discuss their hobbies and interests and what activities they wanted to engage in during their admission. The recreational nurse added that where appropriate, relatives/carers were contacted for information on the individuals' interests, this was confirmed by the relative/carers spoken with.

We heard that there was not a structured activity timetable for the ward as individuals had historically not responded well to structured groups and instead benefitted from a more person-centred approach to engagement in activity and occupation. Nevertheless, there were regular activities available, such as opportunities to engage in jigsaws, mindfulness, arts and crafts and quizzes.

We saw that there was a daily newspaper session – the 'coffee and newspaper group' - that promoted discussion with the individuals' views regarding current

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

affairs and also an opportunity to provide feedback on activity and the ward in general.

We were told that the recreation nurse organised themed and seasonal activities for individuals in Merchiston Ward. The recreation nurse and individuals that we spoke with told us that they had attended a show at the Edinburgh Fringe Festival and that plans were underway to create a Halloween theme in the ward.

In addition to ward-based activities, individuals were able to attend activities such as 'The HIVE', a day service run by SAMH and Artlink, both situated in the grounds of the REH. The Hive offered a variety of activities and groups. We also heard that some individuals attended the library and gym in the hospital site and the OTs offered groups out with the ward, such as pottery. We heard that the ward had volunteers who attended regularly. We saw the therapet on the day of the visit and heard that a musician attended the ward monthly.

Individuals that we spoke with said that they were "bored" at times. When reviewing care files, we saw that individuals were being offered and supported to engage in activity and occupation however, low motivation levels were a factor in individuals choosing not to engage in activities offered.

We found that the activity and occupation on offer was not recorded in activity care plans and that the recording of activity in care records was variable. We saw that OT's and music therapist regularly recorded the activity individuals engaged in however, this was not consistently done by nursing staff. We raised this with the recreational nurse, CNM and CN who agreed that a more proactive approach to ensuring all individuals had activity care plans and that activity was recorded was necessary.

Recommendation 4:
Managers should ensure that activity participation is recorded and evaluated and that activity care plans are person-centred, reflecting the individual's preferences, care needs and outcomes.

The physical environment

The ward environment required some areas of improvement to promote a less clinical and more welcoming, clean, homely and therapeutic environment. One of the corridors leading to individuals' bedrooms was particularly stark and clinical, with staining on the floor.

We saw that there had been artwork on the walls that had been taken down. We heard from the CN that an acutely unwell individual in the ward had removed the artwork and it had not been replaced. We did however see that the adjoining corridor had artwork on the walls and commented on how this promoted a more homely and

welcoming environment. The CN and recreational nurse told us about plans make improvements to the environment by placing more artwork and murals on the walls.

The lounge and dining area were situated at the entrance of the ward. Individuals tended to spend a lot of time in these communal areas, and we noted that it was busy on the day of the visit with individuals using the areas to watch TV, have a hot drink and use the space to meet with family. With the support of staff, individuals were able to use the kitchen facilities which were attached to the communal area to make a hot drink and snack and had access to the outside courtyard until midnight.

We were able to see some of the individuals' bedrooms. The bedrooms we viewed had ensuite facilities and were personalised.

We had concerns over the use of rooms in the ward. On the day of the visit, the quiet room had a surplus bed in it. The quiet room did not have washing or toilet facilities, compromising the individual's right to privacy and dignity. Although we recognise that at times there can be a shortage of beds, we do not consider these rooms appropriate or safe bedrooms.

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

Furthermore, we were concerned that by using the quiet room as a bedroom, this limited the therapeutic and quiet space available for the individuals to use. We heard and saw that the ward environment was busy, loud and at times intimidating for individuals. We would suggest that Merchiston Ward would benefit from having a dedicated quiet space for individuals and staff to have access to during periods of stress and distress and to support de-escalation.

We made a recommendation in the previous report that managers should create a smoke free environment. Although we heard that creating a non-smoking environment remained an issue in the ward, we did not see evidence of smoking on the ward on the day of the visit. We heard that in recent weeks there had been a proactive approach by all members of the MDT to prevent regular smoking in the ward and courtyard. We saw signs on doors leading to the courtyard asking individuals to refrain from smoking. We heard that a date had been set for NHS Lothian 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

We were pleased to see the progress made in many areas since the previous visit and the ongoing efforts made by the team to promote the delivery of rights-based care to individuals. 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 we spoke with had an awareness of the ongoing areas of improvement needed, especially in relation to care planning. 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 Merchiston Ward.

Summary of recommendations

Recommendation 1:
Managers should ensure that there is a system in place for all individuals that is understood and offers 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 care 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 should ensure that all individuals have a risk assessment that records comprehensive information on assessed risk, positive risk-taking strategies, promotion of risk enablement and robust management of identified risk.

Recommendation 4:
Managers should ensure that activity participation is recorded and evaluated and that activity care plans are person-centred, reflecting the individual's preferences, care needs and outcomes.

Recommendation 5:
Managers should consider returning the dedicated quiet room in the ward to 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