mental welfare
commission for scotland

Mental Welfare Commission for Scotland

Report on unannounced visit to:

Dykebar Hospital, North and East Wards, Grahamston Road, Paisley PA2 7DE

Date of visit: 24 June 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

East and North Wards provide care to older adults with complex care needs which cannot be met in other settings. East Ward provides care for females and North Ward for males. The wards cover the Renfrewshire catchment area. On the day of our visit both wards were full.

We last visited this service in May 2024 on an unannounced visit and made recommendations on care plans, multidisciplinary team (MDT) meeting records, the requirements of the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) and maintenance of the garden. The response we received from the service was that all the issues were being addressed and would be resolved before the end of the year.

On the day of this visit, we wanted to follow up on the previous recommendations and look at activity provision and carer/relative involvement.

Who we met with

We met with and reviewed the care of 14 people, eight of whom we met with in person and six of whom we reviewed the care notes of. We also spoke with three relatives.

We spoke with the service manager, and the senior charge nurses (SCN).

Commission visitors

Mary Hattie, nursing officer

Sheena Jones, consultant psychiatrist

Mary Leroy, nursing officer

Anne Craig, social work officer

What people told us and what we found

The relatives we spoke with told us that they were generally happy with staff and were consulted around care decisions. One told us “He is much better than he was before” and “the staff team work together for his benefit.” Another said “staff are amazing, I can’t fault them. I feel my wife is safe here.” We heard that when an individual became acutely unwell staff provided excellent care. We also heard from one relative that they were able to come into the ward for mealtimes with their loved one where they could be involved and that this was important to them.

We also heard from several relatives that staffing levels were not consistent and that this had a negative impact on the activity and safety of the ward.

Several relatives commented on the change to visiting arrangements in North Ward. They were discouraged from visiting in the main ward area and were asked to use individual bedrooms or the small sitting room. One relative told us they got a lot of support and benefit from chatting with other relatives during visits, and the new arrangements meant this had reduced. Another told us that the small sitting room used for visits had no television. Both they had enjoyed sitting and watching television together, as due to the lady’s illness, their ability to converse was limited.

One person who spoke with us complained that they were bored and there was nothing to do; they also spoke of the food “always being the same.”

We were told by a relative and by staff that food was an issue. Meals arrived on the ward already plated in individual trays. The food was not appealing and due to the high level of support individuals on the wards needed, food could be cold by the time everyone had a chance to eat.

Following a relative raising this through the hospital management system and directly with Scottish Government, action is now being taken and a new approach is due to commence imminently. The meals will be arriving in a heated trolley in bulk containers so that this can be plated on the ward by catering staff. It is hoped that this will allow more flexibility and ensure food can be served warm to everyone. We look forward to seeing the outcome of this on our next visit.

Care, treatment, support, and participation.

Care record

Information on individuals’ care and treatment was held in three ways; there was a paper file, the electronic record system EMIS, and the electronic medication management system, HEPMA.

Care plans, nursing assessments, multidisciplinary team (MDT) reviews and chronological notes were held on EMIS, along with paperwork associated with the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

Adults with Incapacity (Scotland) Act, 2000 (the AWI) paperwork was held in the paper file, although we found some Power of Attorney documents and section 47 certificates had also been scanned onto the EMIS system.

In the care plans we reviewed, we found that risk assessments were documented and reviewed regularly. We also found completed "Getting to Know Me" documentation in the files. This provided information on an individual's preferences, needs, background, likes and dislikes, which enabled staff to understand what was important to the individual.

In East Ward, care plans were person-centred and addressed both physical and mental health needs. They were informed by the risk assessments and the "Getting to Know Me" information. These were regularly evaluated, and care plans were updated to reflect changes in presentation and care needs.

In North Ward we found that care plans were lacking in detail and person-centred information and did not address all the issues identified in the risk assessments. Care plan reviews were regular and generally meaningful although we found care plans were not being updated to reflect significant changes in an individual's risks and needs which had been documented in the reviews.

Recommendation 1:
Managements should audit care plans in North Ward to ensure these fully reflect the risks, needs, and personal preferences of the individuals, and are updated as these change, providing training to staff where required.

During our previous visit we found that where individuals suffered from stress and distress, detailed and informative Newcastle model-type formulations were in place. On this visit, we found that there were several individuals who experienced stress and distress did not have Newcastle formulations; their care plans for the management of stress and distress lacked the necessary person-centred information around potential triggers and management strategies. The Newcastle framework and process was developed to help nursing and care staff understand and improve the care of individuals who exhibit behaviours that challenge.

Recommendation 2:
Where individuals experience stress or distress a person-centred care plan should be in place which identifies the triggers, behaviours, and strategies for de-escalation, preferably utilising the Newcastle model.

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.

Multidisciplinary team (MDT)
Both wards now have dedicated input from locum consultant psychiatrists. General practitioner (GP) cover is provided from Monday to Friday. There is dedicated occupational therapy (OT) and an OT technician, physiotherapy, and pharmacy input. The wards are currently without psychology input; this has been the case for over a year. The vacant post has been recruited to, and it is anticipated that psychology input would recommence in autumn 2025.

We heard that both wards had a full complement of registered nurses although had a small number of health care assistant vacancies. However, on the day of the visit North Ward was one staff member short, having had one staff member moved to cover East Ward which was two staff short during our visit. We heard that this was not an isolated occurrence and that due to high levels of clinical activity, and staff absence, staff were regularly moved from North and East Wards to support other areas.

Recommendation 3:
Managers should ensure that ward are staffed to the agreed complement to ensure safety and meet the needs of the patient group.

Social work are involved on a case-by-case basis. Input from speech and language therapy, dietician, other allied health professionals and specialist services was available by referral.

Previously we made a recommendation regarding the recording of MDT reviews. We were pleased to find this has been implemented. MDT meeting notes contained information on who attended, provided a summary of the individual's recent presentation and care needs and a record with details of decisions taken, actions required and who was responsible.

The requirement for NHS hospital care is reviewed on a regular basis. We heard that relatives and proxy decision makers were invited to reviews on a six-monthly basis, and if unable to attend, their views are sought and recorded.

Use of mental health and incapacity legislation

On the day of the visit, nine people were detained under the Mental Health Act. All documentation relating to the Mental Health Act was in place.

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

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3s) under the Mental Health Act were in place where required and corresponded to the medication being prescribed. However, in North Ward these were not readily available in the treatment room to enable staff to check the legal authority for medication they were dispensing. We found one individual who had recently been detained but was now informal and was prescribed intramuscular (IM) medication. This was discussed with the SCN who contacted the consultant to review this.

Recommendation 4:
Managers should ensure that the T3/2 and s47 certificates are held in the treatment room to enable staff to confirm that legal authority to treat is in place.

Where an individual had granted a POA or was subject to a guardianship order, details of powers granted, and the contact details of the proxy should be held on file. Where a proxy was appointed copies of the powers were available in all the files we reviewed.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We noted that since our last visit the review date for section 47's was recorded on the ward patient information board. However, one of the s47 certificates we reviewed in North Ward was out of date. This was raised with the SCN on the day.

Rights and restrictions

The doors to both wards are secured by a keypad entry system. Visitors enter and exit with the assistance of nursing staff. There was information about this on display near the door. Open visiting was in place in both wards. Visitors could visit in the small sitting room, the garden areas or the individual's bedroom and could also use the grounds.

Five people were delayed discharges. The reasons for these were either difficulties in finding appropriate care home placements, or families contesting the decision due to their concerns, on occasion with a history of previous care home placements breaking down. In all cases this was being actively managed.

Advocacy was available and this information was on display.

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

Activity and occupation

There was an activity programme displayed in each ward. The occupational therapist and therapy technician provide activity. This included a range of small group and individual activities to meet the needs and preferences of the individuals, such as, reminiscence, quizzes, games, exercise, music groups and breakfast groups. The physiotherapist and occupational therapy technician do a joint exercise group weekly in each ward.

Individuals were also supported to attend church services on a virtual basis. There were regular therapet visits. The wandering minstrel who provided a regular weekly music event has now retired and this service has not been replaced.

In East Ward, there was a weekly choir group and North Ward had football memories sessions.

Nursing staff try to spend time in informal activities, chatting with individuals and taking them for short walks around the ward however, the high levels of clinical activity and staffing constraints limit their ability to do this. North Ward has a health care assistant activity co-ordinator.

Recommendation 5:
Managers should review the activity provision in the ward to ensure that all individuals are provided with a range of activities to meet their individual needs and abilities.

There were detailed occupational therapy care plans and occupational therapy staff record activity participation in the chronological notes however, we found several individuals, with significant cognitive impairment which may limit their ability to participate in the group activity programme, who did not have any activity recorded.

Recommendation 6:
Managers should undertake regular audits to ensure that activity is being provided and recorded.

The physical environment

Both wards have the same layout, which comprises of 21 single en-suite bedrooms. We noted personalisation in a number of bedrooms, with family pictures and

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

personal items on display. There is dementia friendly signage throughout both wards.

Each ward has a small, quiet sitting room and an activity room, both with direct access to a secure, level garden area with covered seating that provided a very pleasant and useable outdoor environment. We made a previous recommendation that the weeds in the paving be attended to. We are told this was done, however there is no regular maintenance schedule for this, and the weeds have returned.

The activity rooms are used for breakfast and lunch groups as well as various group and individual activities. On the corridors there were several activity boards and pictures of sporting celebrities and local scenes.

In both wards the main sitting and dining area join with the corridors in the central hub of the ward, with several bedrooms off this area. As a result, this area is a busy thoroughfare. Due to the limits on space, a significant number of people have their meals in the same chair in which they spend most of their day.

Natural light is provided via a large skylight; we were told by staff this can make the wards uncomfortably hot in summer. There were no other windows in these areas. Attempts have been made to mitigate the lack of windows with murals of outside scenes and pictures, to add interest to the walls. However, most people spend much of their day in these areas where there is no external view. Limited use is made of the two sitting rooms, in part due to staffing levels and the need for supervision of individuals for safety.

We have repeatedly stated that we feel the wards are not fit for purpose and do not provide a suitable environment to meet the needs of the client group. We were therefore very concerned to hear that there is a proposal that the catchment area of the ward, which is currently Renfrewshire, be increased to include East Renfrewshire and Glasgow South.

We are aware that the older adult's mental health service review has been ongoing for some years now and has not yet been concluded. Therefore, we are unaware of any proposed solutions to the accommodation issues which may be being considered, or the timescales for these. We look forward to receiving this report soon.

Recommendation 7:
Greater Glasgow and Clyde health board must prioritise taking action to provide an environment which is fit for purpose and meets the needs of the current patient group before making any change to the catchment area for these wards.

Summary of recommendations

Recommendation 1:
Managements should audit care plans in North Ward to ensure these fully reflect the risks, needs, and personal preferences of the individuals, and are updated as these change, providing training to staff where required.

Recommendation 2:
Where individuals experience stress or distress a person-centred care plan should be in place which identifies the triggers, behaviours, and strategies for de-escalation, preferably utilising the Newcastle model.

Recommendation 3:
Managers should ensure that ward are staffed to the agreed complement to ensure safety and meet the needs of the patient group.

Recommendation 4:
Managers should ensure that the T3/2 and S47 certificates are held in the treatment room to enable staff to confirm that legal authority to treat is in place.

Recommendation 5:
Managers should review the activity provision in the ward to ensure that all individuals are provided with a range of activities to meet their individual needs and abilities.

Recommendation 6:
Managers should undertake regular audits to ensure that activity is being provided and recorded.

Recommendation 7:
GG&C Health board must prioritise taking action to provide an environment which is fit for purpose and meets the needs of the current patient group before making any change to the catchment area for these wards.

Service response to recommendations.

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia, and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

When we visit:

- We find out whether an individual's care, treatment, and support are in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia, and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice, and guidance to people we meet with.

Where we visit a group of people in a hospital, care home, or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports, and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line, and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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

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