Mental Welfare Commission for Scotland

Report on announced visit to:
Ayr Clinic, Arran, Bellisle and Low Green Wards, Dalmellington Road, Ayr, KA6 6PT

Date of visit: 6 November 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

Ayr Clinic is an independent hospital that offers mixed-sex, low secure care across three wards. The wards are Arran, which has 12 female beds; Belleisle which has 12 male beds; and Low Green, which also has 12 male beds. All wards provide care for individuals with a primary diagnosis of mental illness, personality disorder and/or mild learning disabilities. All were subject to compulsory treatment provided under the Mental Health (Care and Treatment) (Scotland) Act, 2003 or the Criminal Procedures (Scotland) Act, 1995. On the day of our visit all wards were at full capacity.

We last visited Ayr Clinic in October 2024 on an announced visit. The recommendations we made for that visit were to support bank and/or agency staff to communicate in a therapeutic way and recognise difficulties people face at times of stress and distress. We recommended that an audit of adults with incapacity documentation, including s47 and welfare guardianship orders was required and to ensure that the documentation was available to staff. The response we received from the service confirmed that an action plan was in place that addressed these recommendations

Who we met with

We met with, and reviewed the care of 13 people, meeting five in person on the day. We also spoke with four relatives by telephone.

We spoke with the hospital manager, the clinical director, the ward managers and two consultant psychiatrists. We also met with the head occupational therapist (OT) and the head of psychology services.

Commission visitors

Anne Craig, social work officer

Mary Leroy, nursing officer

Gemma Maguire, social work officer

Justin McNicholl, social work officer/senior manager (projects)

Denise McLellan, nursing officer

Dr Rachel Lee, ST6 LD Psychiatry Trainee

What people told us and what we found

Generally the people we spoke to were positive about their care and treatment in Ayr Clinic. One person said that his move to Ayr Clinic was “great”. We were told that people attend their monthly individual care reviews and staff take time to go through their care plans with them. Psychology and OT were valued by individuals and we saw evidence of people being involved in their care plans and spending time with staff.

Some people said that they had lots to do, although others said that there were not enough activities.

We heard from a relative that there had been a delay for their family member accessing the gym, although this had been since resolved. The delay had been because of a need for an induction to the gym, which had to be provided by someone outside the organisation. We were told that everyone who uses the gym requires an induction and use of the equipment is individually risk assessed.

Several people said they saw that staff were under pressure and felt it was difficult for them to provide the care they wanted but we were also told that staff were “approachable” and that they were “good”.

We heard from people that had witnessed restraint taking place that it could induce feelings of fear and distress. One person told us that “staff never check in on you after [the incident] as they have to be with the person who is kicking off”. Another person told us that when they asked for help they were told that “they [staff] didn’t have time just now as [they] had just come out of an hour-long restraint”. This person commented that “staff are so stressed but they should not be saying this to patients”. For some, we heard that they “don’t feel safe at times because of other patients being so aggressive”.

Another person was able to talk about the restrictions placed on them but said “I understand why, they tell me and involve me in decisions”. Another person suggested that providing a “debrief” to people after needing to be restrained would be helpful to understand what happened. We were told the service are able to evidence debrief with the DATIX incident recording system, 24 hour, and 72 hour reports, team incident review documentation and patient debrief forms.

Recommendation 1:
Managers should ensure that following incidents staff and individuals are offered debrief and records should clearly state when debriefs are offered including when someone declines and that auditing of these records can support consistent practice in line with policy.

Many people were complimentary about the medical staff, one said “my doctor (RMO) knows me well”. We heard from one individual who said that they were “supportive” and from another that “my doctor (RMO) is very good. I like him. He is straight forward. If something needs said to me he says it”. Another person told us how important it was for them to keep contact with their family, telling us “I get to see my family even though they live miles away and see my sister’s dog. I really love that”.

We were told by people that they get “real work” opportunities by working in the shop and one person has started an Open University course, commenting, “my OT and the OT assistant are so supportive”.

We heard from one person that the food was good; others were less complimentary about it. One person said “I have a lot of allergies and staff have had to argue with kitchen at times”. The service advised that menus are changed frequently (6 weekly basis) and are monitored through the monthly quality walk rounds where patients have input. The menus are also discussed at patient forum prior to any menu changes.

Several people we spoke with said that there were a lot of agency staff used, especially on night shift. One person told us that they felt that “sometimes they do not want to interact with me and seem scared as if they don’t know what to say to me. They talk over me to each other but the normal staff are great and always make time but they are just so busy”. We made a recommendation about this on our last visit and we have been told that all bank and regular agency staff have access to the same training that permanent staff receive.

Recommendation 2:
Managers should ensure that bank and agency staff are confident and able to provide the support that people need and ensure that the individual is at the centre of any interactions on the ward. Due to continuous turnover of agency staff the actions previously identified to address this issue should continue.

Care, treatment, support, and participation

Care records

Ayr Clinic uses their own electronic recording system, Care Notes, which was easy to navigate and intuitive to use. When Commission staff were looking for specific information, such as a suspension form, we were told it was on a shared drive which we did not have access to on the day, however we were able to see most of the records and able to access information relating to a person’s journey, their daily care records and care plans.

Care plans were detailed and well developed. We could see where the person had input to their care plan and they were offered copies for them to keep; we also noted

where people declined to have their own copy. It was clear to see how the interaction of the care plans supported decision making by the multidisciplinary team (MDT).

Care plans evidenced mental and physical health and showed details about a person's physical condition. All physical health assessments had been completed and care plans were bespoke to the people on the ward, reflecting that the staff on the wards knew them well. The care plans were regularly updated and any amendments were discussed with the person.

On our last visit we made a recommendation about auditing care plans. We were pleased to see that this had been actioned and that there has been an improvement in the quality of the care plans.

There was evidence of staff spending time with people on an individual basis and also in activities, supporting them to spend time off the ward or in the vicinity of the local community.

We could also see robust risk assessments which were regularly updated; these were also part of the discussion at the MDT meeting. The risk assessments were supplemented by information provided from psychology input and from occupational therapy interactions. We saw detailed risk management plans and we also viewed care plans reflecting the work of different disciplines such as occupational therapy and psychology.

Multidisciplinary team (MDT)
Each ward has a dedicated responsible medical officer (RMO); there are four in total. There was flexibility in the medical team across all three wards. There is an in-house psychology team, nurses, care support workers, and OT staff.

An MDT meeting for each person took place on a monthly basis. People were invited to attend the MDT and relatives could attend if they are able to or they were updated following the meeting, by either the nursing team or the RMO. We were told by one relative who was unable to visit that they were pleased to be able to receive regular updates from the staff.

We asked about the availability of advocacy services and were assured that this was on offer if staff felt it was needed or if the person made a request. We noted in several of the care notes that advocacy was being suggested to support the person's voice being heard.

We noted that there were discussions with the MDT about potential discharge plans for several of the people across the wards. It was positive to note that one person was on pass from the ward and that it was likely that their detention order would be converted to a community based one in the future.

We noted there were challenges with several people, particularly in relation to accessing appropriate housing and community care provision. People in Ayr Clinic come from all over Scotland and discussions in relation to discharge planning take place with several health and social care partnerships (HSCPs).

We heard from the head of psychology that Ayr Clinic psychology service is well established and supported trainees to become qualified practitioners. Psychology was noted to be integral to the health and safety of the individuals and the staff in Ayr Clinic. A number of individuals who spoke with us told us how valuable psychology was for them. We heard how this service aides risk assessment and clinical formulations and also looks to support people in considering how their behaviour has had an impact on their current situation, as well as considering the changes needed to support their futures. We heard of the different techniques that were being used and how the service continued to learn and promote new innovations in psychology provision.

Use of mental health and incapacity legislation

On the day of our visit, all individuals in the wards were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure Act).

The individuals we met with during our visit had a good understanding of their detained status, of their right of appeal, and how to access advocacy and legal advice.

All documentation relating to the Mental Health Act, Criminal Procedure Act and Adults with Incapacity (Scotland)Act, 2000 (the AWI Act), including certificates around capacity to consent to treatment, were in place and had detailed care plans attached.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required. We did discuss some anomalies on the day with medical and nursing staff and these were amended on the day.

We were pleased to see that when people were receiving their medication this was in a private space just outside the main area of the ward. There was an emphasis on privacy and arrangements were in place to ensure that when medication was being administered, the ward door was monitored. When people were to receive depot medication, this was done in the privacy of their bedroom.

Any individual who receives treatment under the Mental Health Act or the Criminal Procedure Act can choose someone to help protect their interests; that person is called a named person. Where an individual had nominated a named person, we found copies of this in the individual's file.

When we review 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. We noted that many of the individuals had completed an advanced statement.

Rights and restrictions

Ayr Clinic, as a low secure forensic unit, operates a locked door policy commensurate with the level of risk identified in the patient group.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where an individual is a specified person and where restrictions are introduced, it is important that the principle of least restriction is applied. All individuals in Ayr Clinic are specified persons. We did note that individuals, although having free access to the ward telephone, were restricted to having mobile devices in the main ward areas, with devices being available on a personal level in private areas, such as bedrooms. This was to manage safety and security concerns, regarding internet and camera use, and on several occasions we saw that this had been noted in the individual's specified persons documentation, accompanied with a reasoned opinion. The people we spoke with understood why they were a specified person and said that this had been explained to them.

One relative told us that a booklet about Ayr Clinic would have been helpful for them to understand what could be expected from the service and to outline any restrictions that may be applied to their family member.

The Commission has developed *Rights in Mind.*[1] 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

We heard from some people that the activities on offer were "great" and very much appreciated but other people said that there was not much to do. We noted in each ward that there was an activities programme, which was supplemented by staff who would spend time supporting people with activities, such as spending time in the

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

gym or getting outdoors. There is a vegetable garden where we heard people had enjoyed gardening.

We were told about a yearly music festival that takes place in the garden area and some of the staff and the individuals can take part. We also heard that there is an individual who is a talented DJ and they were able to perform this year and there had been a barbecue during the festival.

We met with the head of occupational therapy who told us about how they provided a programme of activities which was reflective of people's profiles on each ward.

We were told that the activities are sometimes led by the individuals on the ward, for example, on the female ward there is a "knit and natter" group. The activity programmes for each ward were innovative and person-centred and encouraged interactions with other groups outside of Ayr Clinic. Some people could go swimming, dog walking, horse riding, attend a sports group, cooking, budgeting and there were more sessions where there was a focus on learning new skills.

Records noted engagement and instances when people had declined activities; these were available in the care records. We heard from the head OT that it could be difficult to engage some people with the programmes on offer.

The physical environment

The layout of the each of the three wards consisted of 12 beds, which had a central communal area with a dining room, seating area, lounge, activity room and laundry room where individuals could do their own laundry on a rota basis. There was a small kitchen area with tea/coffee available for people without any restriction. On each wing of the central area there were six en-suite rooms.

Ayr Clinic operates on the Safewards model. Safewards is an organisational approach to delivering inpatient mental health services. The aim of Safewards is to minimise the number of situations in which conflict arises between healthcare workers and patients that could lead to the use of coercive interventions (restriction and/or containment). We heard how Safety Pods are being used and that evidence has shown that their use has resulted in reduced restraint periods from one hour to 20 or 30 minutes.

We saw posters on walls advising people of our visit and staff were actively encouraging people to talk to us about their experiences. On the walls we saw positive messages from people who had moved on, to motivate those currently on the ward to have hope and look to the future.

We did note that the wards were cramped and not particularly fit for purpose but have no adverse comments on the accommodation or the outside space. We saw that in one room we visited, the paint was peeling from the ceiling and there was

some evidence of neglect on the walls and the floor. We brought this to the attention of the clinical director during our visit as a positive environment is critical to improving and promoting good mental health. We were told that there is programme of maintenance in Ayr Clinic and this would be highlighted to the maintenance team for remedial action.

We noted that there were positive actions taken in removing any potential ligature risks from people while they spent time in their rooms. We also saw anti-barricade doors have been fitted in specific rooms.

Any other comments

We were pleased to hear that there was robust staff supervision. Staff receive clinical supervision monthly and support was provided by the psychology team for reflective practice sessions. We were also told that a mid-shift meeting takes place which supports team communication during the shift on a proactive and not reactive basis, so that staff can be aware of potential changes with the ward population.

Summary of recommendations

Recommendation 1:
Managers should ensure that following incidents staff and individuals are offered debrief and records should clearly state when debriefs are offered including when someone declines and that auditing of these records can support consistent practice in line with policy.

Recommendation 2:
Managers should ensure that bank and agency staff are confident and able to provide the support that people need and ensure that the individual is at the centre of any interactions on the ward.

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.

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