Mental Welfare Commission for Scotland

Report on announced visit to:
Dykebar Hospital, Arran Ward, Grahamston Road, Paisley, PA2 7DE

Date of visit: 12 May 2026

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

Arran Ward is a mixed-sex, 20-bedded unit in Dykebar Hospital that provides mental health rehabilitation and recovery for individuals across the Renfrewshire area.

On the day of our visit, there were 20 people on the ward and no vacant beds. 19 people were receiving care from the rehabilitation and recovery team, and one person was 'boarding' in the ward as the relevant general adult psychiatry ward was full.

There are eight single rooms in the rehabilitation service. People can receive 'short term rehabilitation' for up to two years while people in the recovery service can remain in hospital much longer, due to their multiple physical and mental health care and support needs. There are 12 recovery beds in the service, set out in two four-bedded dormitories and four single rooms.

We heard from staff how the length of admission is based on individual need, with people moving between the rehabilitation and recovery services. We also heard that there had been several discharges from the service since our last visit and a continued focus on supporting people to move from hospital to community settings.

We last visited this service in March 2024 on an announced visit and made four recommendations at that time. Recommendations focussed on completion of treatment plans for section 47 certificates, monitoring of covert medication care pathways, specified person processes and ensuring that individuals have access to meaningful activity and occupation, seven days a week.

The response we received from the service included information about the new and updated audit processes in relation to section 47 certificate treatment plans, covert medication care pathways and specified person documentation. We also heard about activities being timetabled seven days a week and an increase in staffing levels to support this.

On the day of this visit, we wanted to follow up on the previous recommendations and hear from people and their families and carers about their care and treatment.

Who we met with

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

We spoke with the inpatient operations nurse manager, the senior charge nurse, the consultant psychiatrist and lead occupational therapist.

Commission visitors

Dr Adebola Adegbite, higher trainee
Dr Sheena Jones, consultant psychiatrist
Mary Leroy, nursing officer

What people told us and what we found

We heard from several individuals that we spoke with that the staff "really looked after them" and "looked after them well". We heard from people that they were able to go out from the ward and that they enjoyed the day trips. We heard that people had "good contact with their doctor" and that the staff communicated well with them.

We saw people being supported with care and attention during our visit to the ward. The staff team knew the individuals in the ward well and were able to provide us with all the information that we needed in relation to our enquiries. It was evident that the staff team took a person-centred and recovery focussed approach to people's care and treatment. This is particularly important for those individuals whose motivation levels are limited by their mental health and who have been in hospital for long periods of time.

One relative told us that the "staff looked after their relative well". They said that they were able to take part in ward meetings and this included being able to join remotely when this was more convenient. They spoke about the efforts of the team to identify a suitable home for their relative in the community. Their only concern was about how long their relative would be able to stay in the service due to the housing development around the hospital and whether the service would at some point close.

We heard from senior staff that there had been no significant incidents or complaints since we last visited the service.

Care, treatment, support, and participation

Care records

We reviewed people's care records on the electronic EMIS system and prescribed medications on the electronic HEPMA system in addition to reviewing paper records. Paper records included some legal documentation, legal authority for medical treatment forms and certificates and information about each person. We were easily able to find all the information that we required.

We saw regular recording by the nursing team of each person's mental state, progress and activities. Nursing staff regularly recorded the one-to-one time that they had with people and discussions and information sharing with families and carers.

We found person centred-care plans (PCCPs) for all individuals whose records we reviewed. These were detailed and covered a wide range of physical and mental health needs. Where possible, the PCCPs included the views of people, families and carers and we saw copies that had been signed by the individuals. The PCCPs were regularly reviewed and updated, and it was clear when changes were made.

In addition to people's mental health care, we saw that their physical health was regularly considered with routine observations being recorded, including physical investigations, involvement of allied health professionals and referrals to relevant health services as needed. We saw copies of a comprehensive annual physical health check in people's care, ensuring that their broader health needs and health prevention were considered, including bowel screening and cervical screening. This is important given that many individuals in the ward have a range of physical health needs and may spend long periods of time in hospital.

A number of people in the service had chronic physical health conditions that had an impact on their day-to-day functioning and were associated with progressive decline. We saw "treatment escalation plans" in people's records, which are anticipatory care plans that detail what care a person will benefit from should there be a further decline in their physical health. They were detailed, individualised and included the views of families and carers where appropriate.

We also reviewed cardiopulmonary resuscitation (CPR) care plans and where it was considered that an individual would not benefit from CPR ("do not attempt resuscitation" or "DNACPR"), the rationale for this was clearly documented. The forms also documented when this had been discussed with the person and their family or carer, or the reasons why this was not possible.

The service uses a standard risk assessment and management tool or "CRAFT" tool. We saw that these were regularly completed for each person and included risks in relation to physical as well as mental health needs in keeping with the person's care plans. The CRAFT documents were regularly reviewed at the team meetings, in response to specific incidents and updated.

Multidisciplinary team (MDT)

Arran Ward has five members of nursing staff on duty 24 hours per day, comprising two or three trained staff working with healthcare support workers for every shift. We heard that there has been some staff sickness and a few trained staff vacancies but this had not had an impact on the delivery of care and treatment.

The MDT comprises a consultant psychiatrist, clinical psychologist, part time resident ward doctor, occupational therapist, occupational therapy support worker and physiotherapy.

People in the ward can also access speech and language therapy, dietetics, dentistry and smoking cessation services by referral.

The hospital chaplain attends the ward each week.

We heard that the consultant psychiatrist and psychologist were undertaking a training session for the MDT about the negative symptoms of schizophrenia. We

were also advised that the clinical psychologist could offer cognitive remediation therapy where this was considered appropriate as part of a person's rehabilitation, in addition to providing support to the nursing team with a reflective practice meeting each month.

There is additional "STORM" training opportunity planned for the MDT. This in relation to supporting people who are at risk of self-harm or suicide and cognitive behavioural therapy training for nursing staff.

Arran Ward has two MDT meetings each week during which the care and treatment of people in the ward is reviewed. We reviewed the minutes from recent MDT meetings in people's care records and could see that if they wished to, people were able to attend their meeting and that families and carers could also attend. If people were unable to attend then their views, including the views of families and carers were recorded in the meeting discussion and minutes.

In addition to the twice weekly ward meetings there are also "in-depth meetings" twice weekly, during which the MDT could take a more focussed approach to each person's care and treatment.

Some people in the service are also subject to the Care Programme Approach. This is a formal health and social care meeting process that may be used when a person has contact with many services and there are concerns in relation to risk. We heard that there had been delays in the CPA meetings due to administrative staffing issues. The MDT are aware of this and there is ongoing collaboration between health and social care through the ward meeting processes.

We heard from senior staff that there is good joint working with their social work colleagues, supported by an identified social worker who knows the service and individuals well.

We were told by senior staff that there were no people in the ward who were currently subject to processes under the Adult Support and Protection (Scotland) Act, 2007 (ASP) processes. We saw evidence that ASP processes were used when needed.

We asked whether anyone in the service was considered to be a "delayed discharge" meaning that they were ready to leave hospital but there was no agreed discharge plan. No one in the service was a delayed discharge at the time of our visit.

We spoke about the discharge coordinator role, which had previously worked well in the service. We had already heard about the positive progress made in relation to supporting people to leave hospital, however it was noted that the discharge coordinator role had not been functioning as well as it had previously. The intention

was to re-establish this with support from a registered mental health nurse who would liaise with the MDT, the discharge coordinator and the bed manager.

We were also told that there was a monthly “priorities meeting” which was attended by the consultant psychiatrist, social work team, adult social care lead, discharge coordinator and commissioning services during which current community vacancies were considered and allocated.

We spoke about the availability of advocacy support for people in Arran Ward. Advocacy services are provided by the Advocacy Network on a referral basis, with no issues in people being able to access this service. We saw evidence of people being supported by advocacy in Arran Ward.

Use of mental health and incapacity legislation

On the day of the visit, 16 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). We were easily able to clarify each person’s legal status and review the relevant documentation in their paper and electronic care records.

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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where an individual had nominated a named person, we found paperwork for this.

For those people that were under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) we found copies of Powers of Attorney (PoA) or guardianship certificates in files with details of the PoA, or guardians clearly documented.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We saw that each person who was subject to a section 47 certificate had a treatment plan completed on an Annex 5 form. The section 47 certificates were current and had been reviewed and updated where required. The treatment plans included a range of relevant physical healthcare.

Covert medication refers to medicines given in a disguised form to individuals who refuse medication, who are incapable of making decisions in relation to medical

treatment and where the medical practitioner deems the medication necessary. For those who had covert medication in place, we found that the care plans were up to date, person-centred and included discussions with relevant others.

A number of people in the service had been assessed as lacking financial capacity and had financial appointees in place. In such cases, we could see the relevant documentation and individualised spending plans. The latter were regularly reviewed and updated.

Rights and restrictions

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 made a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. We reviewed the notes and relevant legal documentation of individuals who were specified in Arran Ward. We found that all relevant paperwork had been completed and was up to date. We also saw copies of the letters that had been sent to people and relevant others in relation to their status as a specified person. We heard from senior staff that there is an ongoing audit process to ensure that specified persons processes are regularly reviewed.

A number of individuals in Arran Ward were subject to continuous interventions, meaning that they were under the constant supervision of nursing staff. We reviewed the electronic care record and could see that there were care plans in place when a person was subject to continuous intervention. These plans were regularly reviewed and reduced when possible; the care plans clearly linked with the CRAFT risk documentation, the person-centred care plans and MDT reviews.

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. We reviewed a number of advance statements during our visit. We saw one example where the advance statement had been completed many years before and the MDT were supporting the person to update it. We noted that advance statements were considered and documented during the MDT meetings.

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.

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

Activity and occupation

We saw a strong focus on activity for people in Arran Ward during our visit. There were activity timetables on noticeboards in the ward corridor that were easy to read and included activities such as meditation, shopping and cooking, art, a brunch group, a soup and snack group, walks, karaoke, day trips and computer sessions. The ward has a large, 14-seater bus and a smaller people carrier which they can use to support people to access the community.

People in the ward also had personalised activity planners, informed by assessments undertaken by occupational therapy, physiotherapy and the wider MDT. We heard that consideration was being given to appointing additional physiotherapy staff to support ward activities including walking groups.

We heard from the MDT that any staff can support activities. Additionally, there were instances where a registered nurse could support an activity when this has been identified as a specific need because of the individual's care and support plans.

We saw that the activities that people were offered and engaged in were recorded in the person's electronic care records. We saw that people had made real progress while in Arran Ward with improved daily living skills.

We saw photos on the walls of people enjoying day trips and activities, including the angling group, which had been covered by a local paper.

We saw people's artwork on the walls throughout the ward which made the ward more homely. One person was pleased to be able to show us some of their own artwork.

We heard that there is a creative arts coordinator who attends the ward regularly and in addition to supporting inhouse activities, they also support people to access community activities. One person in the ward has been able to start guitar lessons as a result of this.

The people that we spoke to told us that they had enough things to do, and they enjoyed the activities on offer. A family member that we spoke to told us that their relative had a strong work ethic. They valued being able to undertake domestic activities and that the staff in the ward supported them to do so.

Some people in the ward have been in hospital for many years and there has been an impact on their motivation levels, due to their mental health. It was evident that the MDT continued to seek activities for people that they may enjoy and welcomed people taking part in activities on the days they felt able to.

The physical environment

Arran Ward is a large ward, which was created when two smaller wards were joined; there is one continuous circular corridor that is accessed from the reception area at the main entrance.

The ward had wide corridors, plenty of light and was clean. There was a central patio garden area which could be accessed from the corridor and from some of the lounge areas. This was clean and tidy and had some garden furniture for people to use in the warmer weather.

We saw a range of rooms where people could sit together to watch television, take part in activities, eat or sit quietly.

There was an occupational therapy activity room at the rear of the ward and this was being used for an MDT meeting during our visit.

The ward has a therapy kitchen which people could access with MDT staff to undertake cooking to increase their independent living skills. This was fitted with both electric and gas appliances to meet the needs of all.

There is a large treatment room which had an examination couch where people could be examined in a private area, separate from their bedrooms.

The eight single rehabilitation rooms are to the right of the main entrance while the four recovery rooms and two four-bedded dormitories are to the left of the main entrance and along the rear of the ward.

We found the dormitory spaces to be homely. People had their own possessions, the furnishings were in good condition, and the soft lighting made the areas feel less clinical.

The single rooms in the rehabilitation side of the ward all have en-suite facilities. We heard that the single rooms in the recovery area of the service have a sink but no toilet or shower. People in those rooms can use the toilets and bathroom in the main corridor or the shower in one of the dormitories. This can be an issue for females should they be accessing shower facilities in a male dormitory. We heard from the senior charge nurse that the service can be flexible in such cases and use a single room in the recovery service if that best meets the person's needs.

Service response to recommendations

The Commission made no recommendations for this visit.

Although no recommendations were made, the Commission would 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 and should be returned within three months of the publication date.

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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