Mental Welfare Commission for Scotland

Report on announced visit to:
Royal Alexandra Hospital, Ward 39, Corsebar Road, Paisley, PA2 9PJ

Date of visit: 11 February 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

Ward 39 is a 20-bedded unit that provides assessment and treatment for older adults with a functional illness. The ward is situated on the District General Hospital site. The catchment area is East Renfrew and Renfrewshire.

On the day of our visit, there were no vacant beds. The ward had five patients boarding in; two from older adult services who had a diagnosis of dementia and three from adult services, however these individuals were age appropriate for the service. There were no delayed discharges at the time of our visit.

We last visited this service jointly with Ward 37 in December 2024 on an announced visit and made no recommendations in relation to Ward 39.

On the day of this visit, we wanted to look at care planning and communication with carers.

Who we met with

We met with, and reviewed the care of seven people, five of whom we met with in person and two of whom we reviewed the care notes of. We also met with two relatives.

We spoke with the service manager, the senior charge nurse and charge nurses and a consultant psychiatrist.

Commission visitors

Mary Hattie, nursing officer

Anne Craig, social work officer

What people told us and what we found

We met with two relatives, who told us staff were always friendly and welcoming when they visited. One individual spoke very positively about the consistent encouragement and support that staff had provided to their relative and the difference that this had made to their relative's outlook and independence.

We heard from a relative that staff "accepted him for who he is; without their input he would not be where he is now, he is looking forward to life again".

Care, treatment, support, and participation.

Care records

The ward uses the EMIS system for electronic recording of care plans and the storage of paperwork for the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

In the records we reviewed, we found comprehensive, person-centred care plans and detailed risk assessments that addressed both mental health and physical health needs. Involvement of the individual and their proxies were reflected in the care plans.

Care plan reviews were regular completed, meaningful and relevant and care plans were updated to reflect changes in the person's needs.

Multidisciplinary team (MDT)

The ward has input from psychiatrists, occupational therapy staff, pharmacy staff, a physiotherapist, and psychology staff. Referrals could be made to all other services as and when required.

We heard that the ward was at full complement for registered nurses and that recruitment was underway to replace the current senior charge nurse who is about to retire.

MDT reviews were well documented, with clear actions and outcomes. There was evidence of individuals either attending MDTs or having one-to-one meetings with their named nurse or psychiatrist to ensure their views were represented and they were kept informed about decisions.

We also saw that proxies were invited to attend MDTs and there was evidence of proactive contact with them to discuss the outcomes.

Use of mental health and incapacity legislation

On the day of the visit, eight people were detained under the Mental Health Act. All detention paperwork was on file and in order.

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. Where certificates authorising treatment (T3) under the Mental Health Act were required, these were in place and covered all medication.

Where individuals had granted a Power of Attorney (POA) or where there is a guardianship order under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), a copy of the powers granted should be held in the care record and the proxy decision maker should be consulted appropriately; we found that this was taking place and staff were routinely requesting copies of the powers when individuals were being admitted.

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 found section 47 certificates in place for all individuals that we reviewed and who lacked capacity. Their proxy decision makers had been consulted appropriately.

Rights and restrictions

Exit from the ward was via a keypad system. The code for the keypad was prominently displayed on the door.

The ward had an open visiting policy, although due to space limitations, most visits occurred in the dining area or at individual's bedside.

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 a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. No one on the ward was subject to specified person restrictions under the Mental Health Act.

The ward had access to advocacy and details of the service were on display.

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 did not find any statements in the records we reviewed, however for the individuals in Ward 39, this was their first admission to mental health services and they were not well enough to make an advance statement when we visited.

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

The ward has input from an occupational therapist and an occupational therapy assistant, who focused on activity provision.

There was a regular programme of therapeutic and recreational activities on display. This included quizzes, chair-based exercises, Zumba, relaxation, and reminiscence work. The ward also benefitted from art therapy sessions and therapet sessions. We observed people participating in activities during our visit.

We found information on individuals' previous hobbies or activity preferences recorded in the care plans and activity participation recorded in the chronological notes.

The occupational therapist completed home assessments and we heard from one individual about their visits home with nursing and occupational therapy staff, which they found beneficial.

The physical environment

The ward has several single rooms and dormitories that hold up to five beds each.

There is a combined dining and sitting area. This was bright and spacious, however as the area could also be used for activity provision and visiting, it can be busy and noisy at times. There was a small quiet room which was also used for interviews and for relaxation sessions. This meant there was little opportunity for people on the ward to find a quiet space away from their peers.

There was no therapeutic kitchen on site. This limits the occupational therapist's ability to undertake assessments and the team's ability to provide activities such as baking or cooking groups, social lunch, or breakfast groups, all of which could be of benefit to the patients in maintaining and developing their self-care and social skills.

We found posters advertising our visit on display in the main corridor, along with information on advocacy services and relevant local support groups and information.

The Commission has made recommendations in relation to the physical environment of the ward over several years and remains of the view that, despite some improvements the environment is not suitable for the client group. We are aware that the consultation on the older adult's mental health service review is underway and look forward to the outcome of this.

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

Summary of recommendations

The Commission made no recommendations for this visit, although we 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 an 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