Mental Welfare Commission for Scotland

Report on unannounced visit to:
Clonbeith Ward, Ailsa Hospital, Dalmellington Road, Ayr, KA6 6AB

Date of visit: 16 April 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

Clonbeith Ward is a 12-bedded ward in the Ailsa Hospital Campus in Ayr. The ward is designated for the continuing care of adults with a diagnosis of dementia and is one of the few remaining wards on the Ailsa Campus; most of the other services have been transferred to Woodland View Hospital in Irvine.

On the day of our visit the ward was full, with 12 patients who had complex care needs, often with stressed and distressed behaviour.

We last visited this service in November 2023 and made one recommendation that an audit system should be introduced to ensure that all treatment was legally authorised. The response we received from the service was that medical staff would review the documentation that relating to legal powers in the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) and the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act).

Who we met with

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

We spoke with the nurse in charge, student nurses and health care assistants and following our visit we spoke with the service manager and the senior charge nurse.

Commission visitors

Anne Craig, social work officer

Karen Beattie, nursing officer

What people told us and what we found

We spoke with two of the individuals on the ward, although due to advanced stage of cognitive impairment, they were unable to give a detailed view of their care and treatment or their placement on the ward.

Our visit to the ward was unannounced, although we were able to speak to one relative. They spoke about their concerns prior to transferring to Clonbeith Ward but found the staff to be “amazing” and told us that they found the care and treatment to be “outstanding”.

During our visit, we found the ward to be calm and welcoming. We saw staff who were engaging with the individuals in the ward and were clearly enjoying doing this; people in the ward were responsive and benefiting from the interactions with staff.

We noted that some staff have been in the ward for several years and that their work gave them a great deal of job satisfaction.

Staff we spoke to said that it was a good place to work. We were told about the support staff received from managers and their peers that had helped to further their careers.

We spoke with one member of staff who was new to the ward, they said that it has been a very positive experience so far and the support she is receiving was very valuable. A student nurse on a 4-week placement to the ward told us that they had “learned a lot” and that “communication is excellent, with handovers and huddles where you always know what’s happening”. Another member of staff described the team and management in ward as “great; very supportive”, they also said that clear direction was given when needed and that the team “work well together”.

We were also told that there were opportunities for training and development, including stress/distress training. We noted that most staff have undertaken stress and distress training which was evidenced through the quality of the stress and distress care plans.

We did hear that staff felt that they would like more opportunities to be out on outings with the people in their care.

Care, treatment, support, and participation

Care records

Electronic records were stored on Care Partner; the Mental Health Act detention and treatment paperwork was duplicated in a paper file for ease of access.

Care Partner was easy to use and information is readily accessible. The records that had most recently been uploaded to the system were immediately available.

Care plans were holistic, person-centred, detailed and reflected the goals and objectives for individuals. When care plans had been reviewed or updated, these were clear, they reflected the changes that had been made and who was responsible for taking these changes forward. We saw evidence of one-to-one sessions in the care records.

We also saw care plans in place where there were concerns about a person's physical health; information about this was detailed and reflected how the person wanted to be cared for. All the people on the ward had treatment escalation plans in place, recording their wishes, or those of the proxy decision maker.

There were robust risk assessments on file, reflecting the Ayrshire Risk Assessment Framework (ARAF).

We could not locate life history information for people on the Care Partner system. When we asked about this, each person on the ward has information about them held separately which had been collated by family. We felt that completing an individual 'All About Me' would be a welcome addition for staff's knowledge about the person.

Multidisciplinary team (MDT)
We could see that care plans linked to the discussions and decisions at the weekly MDT meetings. MDT records were detailed and attributed an action to any decisions that were taken. In Clonbeith Ward, the MDTs take place every Monday, where there was a four-weekly rolling programme, with three people being discussed at each MDT meeting.

There is dedicated psychology input to the ward and we were pleased to see detailed stress and distress formulations on file that used the Newcastle formulation structure. We could see how this was benefiting and supporting individuals during times of agitation and distress; it also detailed guidance for care staff in delivering on their caring role.

There was evidence of discussions with individuals and their families detailed in the MDT notes, where appropriate.

Families were invited to attend the MDT but geographically it could be difficult for people to regularly attend, although loved ones are updated following the MDT by staff from the nursing team or an identified clinician.

We were told that the service could refer to occupational therapy, physiotherapy, dietetic or social work, but there is no dedicated time from these professionals on the ward, with services based at the Woodland View campus. There was evidence in the notes that these professions were regularly involved in the care of those in Clonbeith Ward and staff reported there was a prompt response to referrals.

We asked about people who could be considered delayed discharges. We were told that while a few of the individuals were being considered for care home placements there was nobody at the time of our visit that was ready to move from the ward.

Use of mental health and incapacity legislation

On the day of the visit, almost all those on the ward were subject to the AWI Act and had either a welfare guardianship or Power of Attorney in place.

Two people were subject to the Mental Health Act and one person was subject to the Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure Act). Access to advocacy was provided as appropriate and we saw information about advocacy services.

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. T2 and T3 certificates were kept in a separate folder in the staff duty room.

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. We did not find anyone with a named person on the ward.

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. Most of the people on the ward had an AWI Act section 47 certificate in place, with a completed treatment plan. One person was subject to section 49 of the AWI Act (awaiting welfare guardianship being determined).

For those people that were under the AWI Act, we found copies of the paperwork relating to Power of attorney, welfare guardianship and section 47 or 49 certificates on file and available to view.

For patients who had covert medication in place, all appropriate documentation was in order.

All documentation relating to the Mental Health Act and the AWI Act, including certificates around capacity to consent to treatment were available on Care Partner and kept in a paper lite file for ease of use.

Rights and restrictions

Clonbeith Ward operates a locked door policy and access to and from the ward is supported by staff on duty who use a keycard. No concerns were raised about the restrictions of entry and exit to the ward and there was a notification about this at the entrance, providing information about how to gain staff's attention by using a buzzer at the outside porch of the building.

At the time of our visit, two people on the ward were subject to continuous intervention support. We saw them enjoying quality time with staff during the support.

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 person is specified in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place under the Mental Health Act, we found a reasoned opinion on file.

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 people who had an advance statement completed. As the people on the ward have varying degrees of cognitive impairment, we recognise that it would be difficult to promote the use of advance statements.

Activity and occupation

We heard from staff how the Reminiscence/Rehabilitation & Interactive Therapy Activities (RITA) tool, an all-in-one touch screen solution that offers digital reminiscence therapy and that has been introduced successfully into the ward; it has also recently been upgraded.

It is a user-friendly interactive tablet that blends entertainment with therapy. Staff reported that even those individuals with significant cognitive impairment appear to benefit from using RITA and would show some recall and enjoyment from using this tool.

We were told that the ward does have an activity nurse/co-ordinator who actively supports the people with activities. The ward has a minibus and they continue to go on outings to Centre Stage in Kilmarnock, which runs regular dementia friendly days, and there were also trips to the seashore for ice cream. Staff provided activity input to the people on the ward and we saw many of the staff supporting people in various activities during our time on the ward.

There are large, enclosed gardens in a courtyard type setting that provided opportunities for activities in a calm, outside space.

Many of the individuals also benefit from escorted time off ward by staff or family.

The physical environment

Clonbeith Ward was refurbished when many of the other wards on site moved to Woodland View. The ward is pleasant with good natural light and the use of pictures, lighting and other items personalised the space, all of which contributed to a pleasant atmosphere.

There were large open spaces in the ward for recreation and meals and a visitors' room that was well furnished and comfortable.

Bedrooms were personalised with photos and belongings and efforts have been made to make them as comfortable as possible; each room has an en-suite bathroom. Outside many of the bedrooms there were memory boxes relating to past lives and these helped people to identify their own room.

Summary of recommendations

The Commission made no recommendations.

Service response to recommendations

While the Commission has made recommendations for this visit, 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 the action plan and this should be returned within three months of the publication date of this report.

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.

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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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