Mental Welfare Commission for Scotland

Report on unannounced visit to:
South Ward, Dykebar Hospital, Grahamston Road, Paisley, Renfrewshire, PA2 7DE

Date of visit: 30 June 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

South Ward is a 15-bedded unit, providing mental health care and treatment for adults aged 18 to 65 years. The ward also has the ESTEEM service, which is a mental health service for individuals aged between 16 and 35 years old, who appear to be experiencing a first episode of psychosis.

The service covers the geographical area of Paisley and Renfrewshire.

On the day of our visit, there were 14 individuals on the ward, with one vacant bed.

We last visited this service in July 2025 on an announced visit. At that time, we made recommendations in relation to person-centred care planning, documentation relating to risk, medication administration, the provision of a reasoned opinion where an individual was subject to specified person measures and the ward cleanliness.

The response we received from the service was that audit processes and staff supervision were being strengthened to improve person-centred care planning, risk documentation, medication authorisation, and the use of specified person provisions. We were also informed that previously identified issues with cleanliness on the ward had been addressed and weekly cleaning schedules were in place.

During this visit, we wanted to focus on issues that had an impact on care and treatment, including the implementation of updated policy and procedure relating to risk documentation and communication with families and/or unpaid carers.

Who we met with

We met with six individuals. We reviewed the care records of three of these individuals and additionally, we reviewed the care records of a further three people.

We also met with one relative in person and spoke with another relative by telephone.

We spoke with the senior charge nurse (SCN), the occupational therapy (OT) technician, the service manager (SM), the operational nurse manager and clinical director (CD).

Commission visitors

Gemma Maguire, social work officer

Dr Sheena Jones, consultant psychiatrist

What people told us and what we found

Individuals we met with described staff as “brilliant” and “excellent”. People told us they felt their views were listened to by nursing staff, occupational therapists, and medical staff, including psychiatrists. One person shared that the service was a “therapeutic place”.

Several individuals said they felt able to raise concerns with staff and had been provided with information about their rights, including access to independent advocacy, seeking legal advice, and making a formal complaint.

Some individuals we spoke with, particularly those not subject to measures under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act), told us they had not received information about advocacy services, although they felt this would be helpful. We raised this with the service during our visit. The SM advised that advocacy services remain available; however, contact information displayed on the ward had been temporarily removed following a change in provider by the local authority. We were informed that this change has since been paused, with the previous provider continuing to deliver the service. The SM and SCN advised that contact details would be reissued and that referrals would continue to be progressed.

Family members we spoke with described the service as “great” and told us they were kept appropriately informed about their relative’s care. One family member raised a concern about an incident in which their relative’s bed had been used for an emergency admission while they were on home leave. They reported that, after escalating their concerns with the service, the matter was resolved.

A review of care records showed that the views of family members, including named persons, were consistently documented, demonstrating meaningful engagement. We also observed that information on providing feedback, as well as the support that was available to families and unpaid carers, was clearly displayed throughout the ward.

Some individuals we met with told us they did not find the group activity that was on offer helpful and felt there could be a greater range of options. We did hear that individuals with leave from the ward could access a variety of community-based groups and supports. We were pleased to find that a range of meaningful leisure and therapeutic one-to-one and group activities continued to be available to individuals on South Ward.

We have previously made recommendations to South Ward in relation to person-centred care planning and risk documentation. We were pleased to find that the service has progressed and made improvements in these areas of practice.

We heard from the SCN that due to resource pressures across Renfrewshire Council, the link social work role is no longer available to South Ward. We heard how a social work assistant had previously visited the ward on a weekly basis, attending multidisciplinary team (MDT) meetings and worked with the service to provide information and support to individuals. We were informed that this change has been implemented recently and is not currently having an impact on individuals on the ward. We were also reassured that the discharge co-ordinator continues to attend meetings and liaise with social work services. We will review any impact of this change during our next visit to the service.

Most individuals we met with on the day of our visit had been admitted to hospital for less than six months. One individual we spoke with had been in South Ward for one year and was assessed as being well enough for discharge. We were informed that there had been delays in their discharge due to safety work required in their home. We reviewed this individual's care records and found that the reasons for the delay were clearly documented and subject to weekly review. We also noted that an MDT approach had been taken to assessment and planning, including involvement from OT and housing support services. The individual was also accessing advocacy and seeking legal advice.

Care, treatment, support, and participation

Care records

All care records, including care plans, MDT records, and risk documentation, were accessible via the electronic recording system, EMIS.

Each care record we reviewed contained detailed care plans that identified key themes and addressed individual needs, including physical and mental health, management of distress, legal safeguards, and discharge planning. Information in the care plans was consistent with the risk documentation and the MDT records. Care plans also included the views of family members, where appropriate, demonstrating meaningful engagement.

While individuals we spoke with told us that staff regularly sought their views, these were not always explicitly recorded in the care plans. We shared this feedback with the service during our visit and advised that recording the individual's own words in the care documentation would strengthen person-centred practice.

Care plans were reviewed consistently and included detailed information about each individual's progress since their admission to South Ward. The care plan themes and review entries were recorded in the same document, with review information documented beneath the theme section. In two cases, we noted that while review sections had been updated, this was not reflected in the main themed sections (for example, changes in legal status under the Mental Health Act).

We also found that some care plan documents were lengthy, as reviews were recorded cumulatively in a single document for the duration of an admission. In one case, a care plan exceeded 60 pages for an individual who had been admitted for almost one year. Locating the most up-to-date information required scrolling through extensive text, which was time-consuming.

We discussed these issues with the service during our visit. The SM advised that consideration would be given to creating a new care plan document for individuals with longer admissions and archiving their historical information where appropriate.

We found that risk assessment documentation was in place for all of the individuals that we reviewed. The risk assessments were updated appropriately, reviewed weekly, and provided detailed information on risk management, including individualised strategies to reduce distress and minimise risk to the individual and others. Risk documentation was consistent with the information that was recorded in continuous intervention records.

Continuous intervention was being provided to three individuals on South Ward who required enhanced levels of observation and therapeutic support to manage the significant risks that related to their mental health needs. Care records evidenced that these interventions were reviewed daily, with clear documentation demonstrating consideration of proportionality and the use of least restrictive measures.

Multidisciplinary team (MDT)
South Ward MDT consists of nursing staff, consultant psychiatrists (CP), junior doctors, pharmacy, OT and psychology.

We are pleased to report that during this visit MDT meetings continued to happen weekly with detailed notes of who attended meetings and clear action points relating to person centred care plans. We also found that individuals and/or their family were invited to attend meetings with their views recorded.

Use of mental health and incapacity legislation

On the day of the visit, eight people in South Ward were detained under the Mental Health Act. All individuals detained under the Mental Health Act were aware of their rights. Several individuals had nominated a named person, were receiving legal advice and accessing 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) were appropriately in place and corresponded with the medication being prescribed. While treatment certificates were accessible via EMIS, we advised that they should also be

available in the folder stored in the treatment room, which is used by nursing staff to verify that appropriate legal authority is in place prior to administering medication.

We identified one individual who had recently been prescribed regular intramuscular (IM) medication that was not included on the certificate authorising their treatment (T3) under the Mental Health Act. Although nursing staff had completed an audit of treatment authorisation certificates, this error had not been identified.

During discussion with the SCN and CD on the day of our visit, it was noted that staff undertaking the audit had not recognised that the newly prescribed regular IM medication required separate authorisation; as required IM medication was also prescribed and this was included on the certificate. We followed this issue up in writing with the responsible medical office and advised them how to proceed.

We also identified one individual who was prescribed as required IM medication, despite not being subject to the Mental Health Act. We discussed with SCN and CD who advised that the person had been subject to the mental health act in the past. The medication had not been given since the person's compulsory treatment ended and was discontinued at the time of our visit. Senior medical staff advised us that they would ensure that the ward doctors induction would include information about the use of IM medication when people are not subject to the mental health act.

Recommendation 1:
Managers and medical staff on South Ward should ensure that all prescribed medication is appropriately authorised under the Mental Health Act.

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 the documentation to be accessible and the named person to be appropriately consulted.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act (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. One person we met with on the day of our visit had a section 47 certificate and corresponding treatment plan in place.

Rights and restrictions

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital. Where an individual is a specified person in relation to this and where restrictions are

introduced, it is important that the principle of least restriction is applied. On the day of our visit, no one on South Ward was specified under the Mental Health Act.

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. Where individuals had an advance statement in place, the electronic system provided an alert to ensure staff reviewing the persons record were aware.

We found some evidence that advance statements were being discussed at MDT meetings, but this was not done consistently. In discussion with SCN, we were advised that nursing staff and advocacy services support individuals to complete an advance statement whenever it is appropriate to do so.

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 met with the OT technician and heard about the range of activities available to individuals on South Ward, including art and relaxation groups, chair yoga, and walking groups. We were advised that activity programmes were regularly rotated to ensure individuals had choice and variety during their stay.

Several individuals we spoke with were accessing local community-based groups. Those who had been admitted under the ESTEEM service could also attend sporting groups that were available across the wider Glasgow area.

Our review of the care records showed that individuals' engagement in activities was discussed at the MDT meetings and reflected in the care plan reviews. We also found that functional assessments were completed for individuals in South Ward, which could support preparation for transition to rehabilitation and recovery services, or discharge from hospital.

The physical environment

South Ward is a spacious and bright environment with ensuite bedrooms and access to a patio outdoor area.

The SCN informed us that some windows in ensuite rooms where not working properly and the décor and furnishing appeared tired and worn. We were advised that South Ward has had extensive health and safety assessments, with significant work

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

planned this year, to improve the safety of the environment, including the replacement of all windows and chairs, with other décor work also being considered.

We understand that the ward will need to be decanted to Leverndale Hospital to allow this work to be carried out. The SM shared that information and support will be provided to individuals, their families and ward staff to prepare them for this move.

Several individuals in South Ward were receiving nicotine replacement therapy which was being encouraged by staff. Despite this, we found that some people were using the garden or the entrance areas to smoke. We also observed some people using electronic vapes in their bedrooms.

The Commission is clear that smoking on hospital grounds is an offence, with individuals being at risk of penalty notices and fines. While the Commission understands that individuals may experience difficulties in relation to nicotine withdrawal, we are aware that other acute adult admission services are effectively managing smoking bans and utilising nicotine replacement and support services. We would encourage NHS Greater Glasgow & Clyde (NHS GG&C) managers to ensure staff have clear guidance regarding implementation of the smoking ban. The Commission will continue to escalate these concerns with NHS GG&C managers.

Recommendation 2:
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

Summary of recommendations

Recommendation 1:
Managers and medical staff on South Ward should ensure that all prescribed medication is appropriately authorised under the Mental Health Act.

Recommendation 2:
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

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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