Mental Welfare Commission for Scotland

Report on announced visit to:

Midpark Hospital, Ettrick Ward, Bankend Road, Dumfries, DGI 4TN

Date of visit: 16 October 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

Ettrick Ward is a 17-bedded, adult admission unit, which provides assessment and treatment for adults from Dumfries, Stewartry, and Stranraer.

On the day of our visit, there were 15 people on the ward, with two vacant beds.

We last visited this service in January 2024 and made recommendations on care planning and specified person legislation. The action plan and response we received from the service focussed on improvements to both care planning and the management/administration of the specified person legislation.

On the day of this visit, we wanted to follow up on the previous recommendations.

Who we met with

We met with, and reviewed the care notes of seven people, four of the individuals we met with in person. No relatives requested to meet with us during the visit.

We spoke with the service manager, the senior charge nurse (SCN) the charge nurse and other nurses who were on duty on the day.

We also had the opportunity to observe individuals taking part in ward-based activities.

Commission visitors

Mary Leroy, nursing officer

Mary Hattie McLean, nursing officer

What people told us and what we found?

We met with several individuals who were keen to tell us they were happy with their care and treatment and that they found the nursing staff to be “kind, approachable and would take time to chat and meet with you”. One individual commented that “staff do all they can for me, but at times the ward can be busy and chaotic”. Another person stated that “the care in the ward is really good; they have a good understanding of what I need” and the medical staff had “helped me with getting my medication right”.

We found that the senior leadership team to be positive role models and while there were many competing demands on this busy ward, the senior nursing staff set a confident tone which was acknowledged by the staff and individuals we met with on the day.

We had the opportunity to meet briefly with several members of the ward-based team and the allied health professionals (AHPs) who provided input into the ward. Staff were keen to tell us they felt supported by the senior leadership team.

Care treatment support and participation

We heard from the team about the recent development of their care plans; they continue to develop opportunities to promote person-centred care and treatment, ensuring that the individual is held at the centre of this process, while also evidencing good collaboration between the clinical team and the individual.

At the pre-meeting with the senior team, we discussed care planning and our recommendation from the last visit. The team had discussed this and looked at service development and training needs in relation to this matter.

We reflected on the action plan provided by the service. We were told the staff had utilised the Commission’s good practice guidance on person-centred care plans. A short life working group met and developed the initial care plan template which has since been reviewed; there were no identified changes required to the template. Nursing staff have been working to create exemplar care plans aligned to the Mental Welfare Commission’s good practice guidance.

We reviewed several care plans and found them to be bespoke and personalised. We found that for individuals who had been admitted to the ward, assessments had been completed in relation to their mental health, physical health and identified risks.

We found that the care that was delivered continued to be person-centred, as were the care plans, which also had a focus on recovery. The care plans were also detailed in terms of both mental and physical health with a focus on building the individual’s strengths and activities, while considering their goals and interests. The care plans opened with the person’s views and goals.

Throughout the care plan we also saw information that captured both the views of the nursing team and the views of the individual. With the evaluation process, we noted that there was discussion and involvement of individuals in their care and treatment. The evaluation was meaningful allowing both the person and the clinical team to have a clear view on progress towards recovery.

We were told that the ward-based team were keen to include relatives in terms of collating information about individuals as this would influence care and treatment. We saw in individuals' electronic files that families and carers were invited to the multidisciplinary team meeting (MDT) and that their views were sought and recorded. Taking time to listen was seen as an essential part of the staff's understanding of individuals in their care and treatment.

We were pleased to find risk assessments that directly influenced care plans, with all assessments having a holistic approach that considered the individuals' complex needs, along with interventions that were required to meet the identified needs. We found risk assessments to be regularly reviewed and updated.

Care records

Individuals' information was held on the electronic system MORSE. We found the care records easy to navigate and they included input from all disciplines. We could see which members of the team were delivering specific interventions, what the outcome of these had been and what progress had been made.

In the daily continuation notes we saw information that reflected an individual's presentation throughout the day. We also found a rich, descriptive narrative on how the individual had enjoyed engagement with the ward-based team. There were notes on participation and engagement in any one-to-one sessions or group activity that was available on the ward.

Multidisciplinary team (MDT)

We heard from the SCN about the benefits of having a team that was fully established with allied health professions (AHPs). We heard that there were staff vacancies in the medical team in the community setting, although the SCN was positive and complimentary on the input and support from the medical staff in the ward, describing a process of continual review, regular weekly MDT meetings, and who were easily accessible access for both relatives and staff when needed.

We heard that due to a current absence in the pharmacy department, they were unable to attend the weekly MDT meeting. The SCN advised us that there is contact by phone with the pharmacy team, and they are available and accessible to provide any expert advice that the ward-based team requires.

There was a range of disciplines providing input into the ward including nurses, consultant psychiatrists, psychology, and occupational therapy. Referrals could be made to other allied health professionals as required.

We were told by the ward-based team that psychology input into the service had continued to have a positive influence with individuals' care and treatment. The clinical psychologist attends the ward once a month. In this session she can offer clinical supervision and psychological formulation for complex patients. For some individuals, guidance and support may also focus on risk assessment and formulation.

Due to the complex presentation of some of the individuals in the ward, there is a view from the clinical team that the service would benefit from more input from clinical psychology.

The MDT met weekly to review individuals' presentations, discuss their progress and any interventions that were required to ensure care and treatment met the individuals' needs.

We reviewed several of the MDT meeting notes and were pleased to find a consistent approach to noting who had attended the meeting, with clear information relating to the individuals' views. There was also evidence of a rich narrative of the discussions, with clear outcomes and actions highlighted. In this documentation we found that families and carers were invited to the MDT meetings and their views sought and listened to.

For all individuals whose discharge was delayed, this matter was managed through regular reviews at the MDT meetings. We heard about meetings that had taken place regularly with senior managers and the clinical team, including service managers and commissioning services. We heard about the value and role of the Patient Flow team who met with the team to review and expedite the process.

On the day of the visit there was one individual who had been identified as having their discharge from hospital as delayed; there were specific reasons relating to the discharge. On review of the discharge plan and in discussion with the individual, we were pleased to hear that progress towards discharge that had recently occurred.

The senior nurses discussed the benefits of having a service-based social worker in the clinical team; the benefits identified were where the role could enhance collaborative work between hospital, community services, and local authority. We were advised that the opportunities for this post were being discussed and considered by the senior team.

Recommendation 1:
Managers should ensure that the wards provision for dedicated clinical psychology input is reviewed.

Use of mental health and incapacity legislation

On the day of the visit six people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). The appropriate detention paperwork was readily available,

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained and 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, other than for one individual, where two treatments had been added to a prescription chart without the required legal authority in place. We raised this with senior managers on the day and were informed that they would be attended to as a matter of urgency.

Recommendation 2:
Managers and the responsible medical officers must ensure that all psychotropic medication is legally authorised and that there is a record of a clear plan of treatment. Regular audits should be undertaken to ensure that the correct authorisation is in place.

Rights and restrictions

Ettrick Ward operates a locked door on entry only and egress is controlled via a push button, commensurate with the level of risk identified with the patient group.

On the day of our visit, there were no individuals who required additional support through continuous intervention.

We heard directly from individuals that they were aware of their rights in relation to the Mental Health Act/AWI Act that they were subject. We were told advocacy services were available and referrals on behalf of individual were responded to without delay. The staff continued to appreciate their input.

On our last visit to the service, we made a recommendation regarding the use of specified persons and the need to ensure that the required legal paperwork was in place and completed accurately at the time, ensuring that individual's legal rights were considered. We advised that paperwork in relation to this should be sent to the Commission timeously.

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 a specified person in relation to these sections of the Mental Health Act and where

restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place, we found that the paperwork and the reasoned opinions were in order.

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 advance statements for the individuals we reviewed on the day of the visit.

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

In Ettrick Ward activities are considered everyone's responsibility. We observed staff who recognised the value of activities and therapeutic engagement as part of their daily commitment to the people in their care. This included the nursing team, who on a daily basis, promoted and encouraged activity for individuals; this took place on a one-to-one basis or in a group. The approach was often dependent on the needs of the individuals, where consideration was given to their interests and the complexity of an individual's presentation. Activities included arts and crafts, gardening, supported walks and exercise in the onsite gym.

On the day of the visit, some individuals spoke to us about the range of activities they had participated in, mentioning the value of the activities and the sense of purpose it gave them. However, two individuals commented that "it could be a long day" and that they felt bored in the ward setting.

A further individual commented on the role of the occupational therapist, mentioning that the assessment process, the development of life skills, support and preparation they had received as they progressed towards discharge from hospital had been helpful.

We were told about input from AHPs and of low intensity psychological work that could be delivered on a one-to-one or group basis. Some of the individuals we met with spoke about input they had received with anxiety and in learning and practicing practical skills like relaxation, techniques, mindfulness and social skills.

The occupational therapists who had input into the ward provided group work and one-to-one sessions and we heard about a group that was held in the main hub on a

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

Wednesday night, as well as ward-based activities on Thursdays and a cycling group. Group activities offered in the ward included baking, crafts and gardening.

We were also told about the 'art in healthcare' sessions. These sessions were accessed at the main hospital hub and were open to individuals, visitors and staff. Sessions took place in blocks of six weeks at a time, with a short break in between. The artwork and feedback was displayed throughout the hospital. We were able to view artwork in Ettrick Ward which was soon to be on displayed in the ward.

We also head about the 'Let's get sporty' group. This group offered individuals the opportunity of both physical exercise and sport. Sessions are delivered twice per week (for a total 3 hours) and took place in the gym/ball court.

The physical environment.

Ettrick Ward offers a pleasant and warm environment. Individuals are accommodated in single rooms with ensuite toilet and shower facilities; there us access to communal areas, with several rooms available in the ward for visits and meetings.

However, we did note in some corridor areas that the paintwork and the ward décor had become tired and there were several scuffed areas, stains and chipped paint.

We were told about a recent issue with regards to the maintenance of the gardens and the grass not being regularly cut. We heard that maintenance was not occurring due to financial restraints and savings. This is of concern, and we discussed with senior managers about the impact on both people's safety and the loss of this therapeutic area for those who chose to use this space.

Recommendation 3:
Managers should review the ward décor and arranged repainting when required.

Recommendation 4:
Managers should ensure that the garden area provides a safe, pleasant, and easily accessible environment for individuals, visitors and the staff team.

Any other comments

We wish to acknowledge the continued commitment the leadership and ward-based team have made to promote and deliver person-centred care and on this visit, particularly the investment and the commitment from the staff team in the further development of the care plans.

We heard consistently from individuals receiving care that their views were sought and that this was important to them too. A sense that they were equal partners in care and treatment was a theme throughout our visit to Ettrick Ward.

There has been a smoking ban in place with all NHS hospitals since September 2022. It is illegal to smoke within 15 meters of any NHS building in Scotland. We discussed with the staff the value of nicotine replacement therapy (NRT) and for some people, there are challenges to participate in the process.

The ward is smoke free, and we heard from individuals that they are advised that they cannot smoke on hospital premises. People commented in our interviews with them that “nobody smokes here”, “I like it here; I have never smoked” “the environment is cleaner, and it is nicer to go into the garden.” However, another two individuals who had never smoked said they had now started.

Summary of recommendations

Recommendation 1:
Managers should ensure that the wards provision for dedicated clinical psychology input is reviewed.

Recommendation 2:
Managers and the responsible medical officers must ensure that all psychotropic medication is legally authorised and that there is a record of a clear plan of treatment. Regular audits should be undertaken to ensure that the correct authorisation is in place.

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Managers should review the ward décor and arrange repainting when required.

Recommendation 4:
Managers should ensure that the garden area provides a safe, pleasant, and easily accessible environment for individuals visitors and the staff team.

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.

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