Mental Welfare Commission for Scotland

Report on announced visit to:
Midpark Hospital, Nithsdale Ward, Bankend Road, Dumfries, DGI 4TN

Date of visit: 18 November 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

Nithsdale Ward is a 17-bedded acute mental health admission unit in Midpark Hospital for individuals in the areas of Dumfries and Nithsdale.

On the day of our visit, there were 16 people on the ward, with one vacant bed.

We last visited this service in December 2024 as an announced visit and made two recommendations on specified person legislation. The action plan and response we received from the service focussed on improvements to the administration and management of specified person legislation.

On the day of this visit, we wanted to follow up on the previous recommendations. We also wanted to look at issues that had an impact on care and treatment, including the participation of individuals' families and/or carers.

Who we met with

We met with eight people, reviewed the care of seven of these individuals and reviewed the care notes of one person that we did not meet with. We spoke with two relatives.

We spoke with the service manager, the occupational therapist (OT), a representative from the local advocacy services, the senior charge nurse (SCN), the charge nurse and other nurses who were on duty on the day of our visit.

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.

During our visit, we were keen to hear the views of individuals receiving care and treatment and to meet with staff.

We met with several individuals who told us that they felt safe in the ward, that nursing staff were supportive and empathetic, that they felt involved in their care and treatment and were listened to when attending the ward multidisciplinary team (MDT) meeting. One individual described the team as “efficient, trustworthy, kind, and they fight for your corner.”

The individuals that we spoke with knew about their rights, their legal status and how they could access support from a solicitor and/or from advocacy services.

A few of the individuals we met with spoke about the quality of the food provided. They commented on the lack of variety and choice, and for one person, there was an issue of portion size. We raised this matter when we met with staff at our end-of-day meeting and we were informed that the senior managers were aware of the issues that related to the provision of meals. We were advised that senior managers were in discussion with catering services to address this matter. We look forward to hearing the outcome of those discussions and solutions that are being sought.

We met with some individuals with complex presentations; they raised the lack of therapeutic individual/group work in the ward, although we were told about the low intensity group work that was provided by the psychological therapist.

The relatives we spoke to were positive about the care and treatment their family member received in the ward. One person described that the facilities were good and that all staff were very attentive. Another relative commented that “all the doctors and nurses spend a lot of time supporting and consoling my family member.”

Relatives stated that their views were sought regarding their family members. During our review of the clinical notes, we saw collaboration with families during the assessment process, and we noted one recent example when the individual’s risk assessment was being shared, appropriately, with the family member.

Ward-based staff that we spoke with were enthusiastic about their service, their role with supporting individuals and their families; they valued the ethos of the ward that promoted a person-centred, strength-based model of care.

We had the opportunity to briefly meet 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.
The care plans that we reviewed were person-centred, holistic, detailed and covered a wide range of needs. Care plans were goal-orientated and detailed the interventions required to meet the goals; they were detailed regular reviews. The evaluations/reviews were integrated into an updated care plan, which reflected the current dynamic care and treatment that was being delivered.

Through the care plans and the review process, it was positive to note that the individuals' voice had been incorporated throughout, even when the individual disagreed with some aspects of the care planning.

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

We heard about recent development work in practice. The project involved formulation in risk management and this development had ensured that the five-areas assessment framework has now been embedded, with staff becoming accustomed to working within a psychological framework.

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 member of the team was 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.

We heard from individuals that nursing staff carried out regular one-to-one meetings and the individual's views were always being sought. This collaborative approach was well evidenced and used in preparation for the MDT meetings. The meeting involved engagement and discussion with the patient on what was going well, where improvements could be made to care and treatment and what mattered to the individual, alongside any issues they wanted to discuss and raise at the weekly meeting.

Multidisciplinary team (MDT)
There were weekly MDT meetings along with regular access to the medical team for both individuals and staff, when needed. There are 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 professional as required.

At present the clinical lead pharmacist is unable to attend the weekly MDT due to absence. The pharmacy technician regularly attends the ward. The SCN advised us that there is contact by phone with the pharmacy team, and they are accessible to provide any expert advice that the ward-based team requires.

There was some input from the clinical psychologist who offers clinical supervision, consultation, teaching and training to the staff team; the staff team valued this input and support. Due to the complex presentation of some of the individuals in the ward, there was a view from both the clinical team and individuals that the service would benefit from more input from clinical psychology.

On the day of the visit, some individuals we met with discussed the need for further psychological assessment and evidenced-based therapies. The clinical team has identified that there is a need for further support for individuals who had a complex presentation and who would benefit from psychological formulation, a dynamic framework through which connection between the individuals' characteristics, their experiences and behaviour can be understood.

The Commission visitors heard that there is a psychological therapist (PT) available to the service and this input is valued; the PT provided low intensity psychological interventions that were delivered often on a one-to-one basis. However, for those individuals who had a complex presentation, the Commission visitors thought that they would benefit from better access to psychological formulation and treatment, to support individuals in their recovery journey.

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

At the weekly MDT meeting, there is a review of each individual's presentation, their progress was discussed and any interventions that were required to ensure care and treatment met the individual's needs were noted.

We reviewed several of the MDT meeting notes and were pleased to find a consistent approach to who had attended the meeting, with clear information relating to the individual's views. There was also 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.

On the day of the visit, there were four individuals who had been identified as having their discharge from hospital delayed; there were specific issues relating to the

delays for the individuals. For those whose discharge was delayed, they were managed through regular reviews at the MDT meeting. We heard that meetings took place regularly with senior managers and the clinical team, including service managers and commissioning services, the delayed discharge co-ordinator and the hospital flow coordinator, who met with the team to review and expedite the process.

We reviewed the electronic notes of one patient whose discharge was delayed and met with the individual. The individual had a good understanding of the process, and their journey towards being discharged from the service, although they were frustrated with the length of time the process was taking. We were pleased to see that the individual was being supported by the local advocacy services.

Use of mental health and incapacity legislation

On the day of the visit, 12 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.

On review of the consent to treatment certificates, for three individuals we identified treatments that had been added to a prescription chart without the required legal authority in place. We brought this to the attention of the senior management team on the day of the visit 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 correct authorisation is in place.

Rights and restrictions

Nithsdale Ward operated a locked door on entry only and egress was controlled via a push button, commensurate with the level of risk identified in the patient group.

On the day of our visit, one individual who required continuous intervention and three individuals who were on enhanced observations. All individuals are provided interventions on a continuum-based approach that is scaled up or down and is dependent on the individual risk and need.

This approach is in line with the local continuum-based intervention protocol, that links with the work from the project with the Scottish Patient Safety Protocol Programme (SPSP) in improving observation in practice.

On our last visit to the service, we made recommendations regarding the use of specified person status and the need to ensure that the required legal paperwork was in place and was completed accurately, ensuring that the individual's legal rights were considered. We advised that 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 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 reviewed this for those who were subject to this restriction. We found that the paperwork and the reasoned opinion 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. We heard from the staff team that there is ongoing discussion with individuals about advance statements and those discussions occurred during one-to-one meetings and on discharge to the community team. We heard that the opportunity for the individual to be supported to write their advance statement was often provided by the community mental health team (CMHT). We would encourage managers to audit records to ensure advance statements are consistently promoted, with discussions recorded in individuals' care records. We look forward to hearing about progress during future visits to the service.

We met with advocacy staff during the visit and heard that individuals had access to independent advocacy when they chose to. Individuals could request advocacy support for meetings or for attendance at a mental health tribunal. We heard that advocacy received referrals from individuals and staff and that they visited the ward on a regular basis.

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 Nithsdale 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. We noted that there was a weekly timetable for recreational activities both one to one sessions and group work.

Activities can include arts and crafts, gardening, supported walks and exercise in the hospital gym.

On the day of the visit, some individuals were able to tell us about activities they participated in and the positive impact it had on their outcomes and lifestyles. Others told us about the activities on offer but that they chose not to participate or engage in these activities; their choice not to participate and engage was also documented in their clinical notes.

The physical environment.

Nithsdale Ward offers a pleasant and conducive environment. Individuals are accommodated in single rooms with ensuite toilet and shower facilities. There is access to several communal areas, with rooms available in the ward for visits and meetings. We did note that one of the bedrooms was out of use, due to damage to the door; staff told us that they have reported this matter and that they are awaiting a replacement door.

Legislation that ensures a smoke free environment in all NHS hospitals has been in place since September 2022. It is illegal to smoke within 15 meters of any NHS building in Scotland.

The ward is smoke free, and people are advised that they cannot smoke on hospital premises. We discussed with the staff and individuals the value of nicotine replacement therapy (NRT) and were told that for some people there are challenges to participate in the process.

Any other comments

On the day of our visit, we discussed with the clinical team their previous work that was carried out through the Scottish Patient Safety Programme (SPSP) on the development of the clinical pause and the continuum-based intervention approach, which is now embedded into practice in the ward, the team received national recognition for the innovative change in practice.

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

We were told by the SCN that the service had recently submitted an expression of interest to the SPSP to be part of the new workstream that will focus on safety and improving communication at points of transition; they were successful in this bid and have recently commenced the programme. The ward plans to develop a joint improvement project between Nithsdale Ward and the Dumfries CMHT. The work will relate to a discharge safety pack, which will include a discharge checklist for staff, and information for patients, such as follow up appointments, contacts for CMHT, and the crisis team, alongside information on the UK-wide helplines such as Breathing Space and Samaritans.

Most importantly there will be a person-centred brief safety planning tool that will be completed before discharge. Key measures and data collection are to be agreed, such as compliance with 72-hour follow up, which will be in line with the objectives of the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), to improve patient experience and reduce risks associated with harm, such as suicide and self-harm.

To achieve this the ward will work in partnership with individuals, families, and carers to design a booklet, ensuring that this capture what is important to individuals. We look forward to hearing about the implementation of this project in practice and hearing from individuals about their experience of this change.

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 correct authorisation is in place.

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.

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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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