



Mental Welfare Commission for Scotland

Report on announced visit to: Dalveen Ward, Midpark
Hospital, Bankend Road, Dumfries DG1 4TN

Date of visit: 6 February 2018

Where we visited

Dalveen is an eight-bedded in-patient unit separated into two wings, a four-bedded rehabilitation unit and a four-bedded enhanced rehabilitation unit. The enhanced unit is a low secure unit for patients with complex needs who require a longer period of rehabilitation and are managed either under the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Criminal Procedures (Scotland) Act 1995.

The unit also has six, one bedroom flats, which patients can move to if further assessment of their independent living skills is required prior to discharge.

The unit is for both female and male patients. However, when we visited there were no female patients. There were seven male patients in the unit at the time of our visit.

The unit multidisciplinary team (MDT) consists of psychiatry, nurses and occupational therapy. Psychology attend on referral. There are good links with community mental health teams and social work as required.

At the time of our last visit, we made a recommendation around consent to treatment documentation and checked on this during the current visit.

Who we met with

We met with two patients and examined the records of all seven patients. We also met with one relative as well as the senior charge nurse, the charge nurse and other nursing staff on duty.

Commission visitors

Margo Fyfe, Nursing Officer & visit co-ordinator

Yvonne Bennett, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

Care Plans

We were pleased to see that care plans had evidence of patient involvement, were person-centred and regularly reviewed. The care plans centred on mental health care needs, and physical health care needs where appropriate. We were told that when in one-to-one discussions, some staff take the opportunity to go over care plans with the patients to ensure they continue to agree with the plans, and are working towards the goals set. We suggested it would be beneficial to the patients if all staff did this as a matter of routine. We also suggested that it would be good practice to routinely offer the patients a copy of their care plan, and discuss how to keep these confidential should they wish their own copy.

Recommendation 1:

Nursing staff should routinely discuss care plans with patients in one-to-one sessions and patient should be offered their own copy of their care plans.

We found MDT meeting notes to be informative and have forward plans in place along with discharge plans where appropriate. We were pleased to see up to date risk assessments in place with behaviour management plans where appropriate.

We were told that at present the occupational therapy input to the unit centres on assessments. They will provide one-to-one support on referral, but do not offer any group work. Although we are aware that activities are happening in the main hospital out with the unit, patients appear to be spending quite a bit of time without specific rehabilitation activity within the units. We were surprised not to find occupational therapy more engaged in the service as patients would benefit from a focussed occupational therapy input in their rehabilitation process.

Recommendation 2:

Managers should review the occupational therapy input to the unit to ensure it is meeting patient needs.

Family/Carer involvement

We noted that efforts were made to involve family/carers where the patients wished this. It was also evident that where a patient did not wish information about their care be discussed with families/carers then efforts were made to support families as far as possible. It was good to see the use of the triangle of care within care files.

The relative we met with highly praised the nursing care in the unit and how involved they felt in the forward planning of their relative's care and treatment.

Use of mental health and incapacity legislation

At the time of our last visit, we had made a recommendation around the provision of consent to treatment documentation for patients being treated under the MHA or the Criminal Procedures Act. On this visit we were pleased to see that all consent to treatment forms were in place and current.

All legal documentation was easily located in the paper files for each patient.

Rights and restrictions

We found that where restrictions were in place, these were appropriately authorised. Patients were aware of restrictions and how to ask for reviews if they wished.

We noted that patients had access to advocacy services and were aware of how to contact the Commission if they wished.

Activity and occupation

We found that much of the rehabilitation activity available to patients is taking place in the community at the Kaleidoscope Group run by Support in Mind. This is a good resource. However, we suggested that it may be beneficial to patients to source other activities to sit alongside what they participate in at the Kaleidoscope Group.

Although each patient had their own activity planner that they devised with their keyworker each week. We found that there was a lack of activity available on the ward. Patients are encouraged to carry out domestic tasks and go for their own shopping to then cook their meals, however, we saw no evidence of any other rehabilitative activity taking place on the ward. As the focus of the ward is on rehabilitation, we would expect to see nurses and occupational therapy staff encouraging patients to participate in more activity within the ward. We would encourage managers to review the activities with a view to ensuring patients are accessing the best rehabilitation activities possible.

Recommendation 3:

Managers should review ward activities to ensure they best meet the patients' needs within a rehabilitation environment.

The physical environment

The units within the ward are bright and well furnished with homely touches such as pictures, rugs and cushions. The flats are small but adequately furnished and equipped. The interview/visit rooms in the corridor outside the ward are pleasantly furnished and welcoming.

Each unit had access to outside space. The open unit had a nice garden with green houses where patients are encouraged to participate in gardening projects when available. However, the enclosed garden that can be accessed by the low secure unit is somewhat sparse and uninviting. Patients also use this space to smoke as there is no smoking on the ward. However, there is nowhere to shelter in inclement weather.

Recommendation 4:

Managers should improve the garden area and consider the possibility of a sheltered area for patient use.

Any other comments

Use of flats

We were told on our last visit in 2014 that the use of the individual flats was being reviewed as they were, at that time, underused. On this visit, we were again told that the use of the flats was being reviewed. We asked about use over the last year and were informed that at one point during the summer, four of the six flats were occupied

for a short time, but since then only one flat has been in use. Occasionally other wards on site have used one of the flats to carry out assessments. We are concerned to hear that such a resource is not fully utilised and request to be informed of the outcome of the current review.

Summary of recommendations

1. Nursing staff should routinely discuss care plans with patients in one to one sessions and patient should be offered their own copy of their care plans.
2. Managers should review the occupational therapy input to the unit to ensure it is meeting patient needs.
3. Managers should review ward activities to ensure they best meet the patients' needs within a rehabilitation environment.
4. Managers should improve the garden area and consider the possibility of a sheltered area for patient use.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Mike Diamond
Executive Director (social work)

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 MWC 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 individual care, treatment and support is 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

telephone: 0131 313 8777

e-mail: enquiries@mwscot.org.uk

website: www.mwscot.org.uk

