Mental Welfare Commission for Scotland

Report on announced visit to:
Midpark Hospital, Nithsdale Ward, Bankend Road, Dumfries.

Date of visit: 4 December 2024

Where we visited

Nithsdale Ward is a 17-bedded adult acute admission unit that provides assessment and treatment for the areas of Dumfries and Nithsdale. On the day of our visit there were 10 people on the ward and seven vacant beds.

We last did an announced visit to this service in June 2022 and made recommendations about the recording of the multidisciplinary team (MDT) meetings and communication between families and medical staff.

On this visit, we heard about the changes in the medical cover to the ward; the ward now has one consultant, three junior doctors and an advanced nurse practitioner (ANP). We wanted to follow up on the previous recommendations and meet with individuals.

Who we met with

We met with and reviewed the care records of six individuals, and for one other individual, we reviewed their electronic notes.

We spoke with two relatives.

We also spoke with the service manager, the senior charge nurse, the occupational therapist, and other members of the nursing team.

Commission visitors

Mary Leroy, nursing officer

Justin McNicholl, social work officer

Graham Morgan, engagement and participation officer

What people told us and what we found

Nithsdale Ward benefits from good leadership and has developed clear processes that enable consistent and well-defined nursing interventions that work well with the demands often found in an adult acute mental health service.

The nursing team appeared motivated and advised us that they enjoyed working in the ward. They were able to knowledgeably answer all queries that we had on the day.

Throughout our visit we saw interactions between staff and individuals that were warm, good natured and relaxed. We saw staff taking time in their communication with individuals. There was a sense of calmness across the ward and staff we spoke to felt it was important that people in their care felt safe and secure.

During our visit we were keen to hear the views of individuals receiving care and treatment. Individuals told us “staff are brilliant; they are always there for you”; “the occupational therapist is proactive and there are always activities to do on the ward”. Many of the individuals spoke positively about the activities that were available on the ward.

We were keen to hear whether individuals felt part of their recovery journey and equal partners in their care and treatment. We heard from those that we spoke with that they had been invited and welcomed into their ward-based meeting and their views were actively sought. We saw in the record of the multidisciplinary team (MDT) meetings evidence of patient participation.

On the last visit to the service, we made a recommendation about communication between the relatives and/or families and the medical staff on the ward. We were pleased to hear from relatives, families and carers that we spoke with about their involvement in their relative's care. They advised us that they had good contact and communication with the medical staff and the nurses. One person stated that “the staff always make me feel welcome. They made time to talk and support me with my concerns”.

When appropriate, families and carers were invited into the MDT team meetings, and there was evidence of their views being actively pursued, highlighting a collaborative approach with individuals, families and carers and the clinical team. The senior charge nurse commented that medical staff also met with relatives if they could not attend the meetings; they would phone or offer a face-to-face meeting.

Relatives and carers had raised the point that they would appreciate an information booklet on the ward. They noted that this would give them helpful information on what the person may need to know, how they could stay connected and about discharge. The relatives acknowledged that most of this information was shared

verbally but they would have benefited from written information. We discussed this with the team at the end of day meeting.

Care, treatment, support, and participation.

Care records

NHS Dumfries and Galloway adopted MORSE, the electronic patient record system for use in Midpark Hospital. The clinical team have been trained in the use of this system which has been live since January 2024. Templates had been created to ensure that accurate information was captured during every meeting which aimed to ensure improvement with cross-team communication.

There are plans that all the individuals' documentation will eventually be held on MORSE, ensuring that information sharing, safety and the wellbeing of the individual is held in one place. Senior managers informed us that the migration of all documentation was currently being reviewed and that they will update the Commission on the progress of those plans in due course.

Individuals admitted to the ward had assessments completed on their mental health, their physical wellbeing and risk. All the assessments we reviewed were comprehensive and person-centred. The team used the SBAR model as a framework for the assessment process.

Care plans are completed on the digital platform MORSE. We found that care plans were person-centred and addressed the full range of care needs for mental health, physical health, and more general health and wellbeing of each individual.

We heard from those that we spoke with that they felt involved in the care planning process, that care plans were discussed and shared with them and that the care plan had a focus on the individual's strength and protective factors.

In the care plan reviews, we saw that these were regularly updated; we found the reviews were thoughtful and detailed the progress and changes in each individual's care.

The risk assessment used in the ward was the Sainsbury clinical risk assessment tool (adapted). This tool highlighted and identified risks, describing them in detail although the model was somewhat restricted due to the lack of an embedded formulation. We found that these were reviewed and updated regularly.

We heard about the service's plans to move the risk assessment from its current platform to MORSE. Senior managers were confident that this process would be completed in the next few months.

Multidisciplinary team (MDT)
The multidisciplinary team consisted of psychiatry, nursing staff, occupational therapy staff, psychology, dietetics and physiotherapy. Referrals could be made to all other services as and when required.

On our last visit to the service, we made a recommendation regarding the recording of the multidisciplinary team meeting and the accessibility of this information. With the introduction of MORSE, this has ensured that the MDT template and respective information is easily accessible.

The detailed MDT meeting notes highlighted all that were involved in an individual's care and treatment, noting who was invited to attend the meeting and who had provided an update.

We were pleased to find that the MDT documentation was of good standard, informative and there was a clear action plan that identified the outcome and the actions for the individual's care goals.

The MDT meeting continued to take place weekly and we were told that all individuals are encouraged to attend the meeting.

We heard from both nursing staff and the individuals that we spoke with how they were encouraged to prepare for the MDT meeting. The individual prepared a written document on what is going well in their care, what could be improved and questions they would like to raise.

On the day of our visit, individuals told us that nurses took time in supporting them with preparation and discussion prior to the meeting. We heard that this was a relatively new approach, and that it had had a positive impact of the process with those that we spoke to telling us "I feel listened to by the nurses and doctors," and I feel involved in my care." For others, we heard "this approach allowed me time to think about questions I may wish to raise." This approach documented and evidenced a collaborative approach to care and treatment.

The team discussed the value of the input from psychology services who focused on those individuals with complex presentations and where there was a need for psychological formulation. This helped to ensure that their complex care needs were met. Psychology also supported the team with training and supervision to meet the needs of those individuals with complex needs.

We asked the SCN about individuals whose discharges were recorded as delayed; there were two patients whose discharge was delayed on the day of our visit. We heard that there was an effective process in place and that a multiagency approach across the health and social care partnership for individuals who were delayed was in place and links were in place with the community mental health teams.

Use of mental health and incapacity legislation

On the day of the visit, nine people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

The individuals we met with during the visit had a good understanding of their legal status, where they were subject to detention under the Mental Health Act. The individuals were aware of their rights, including access to advocacy, and how to challenge detentions under the Mental Health Act. Only one individual was on the ward on a voluntary basis.

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. We found that consent to treatment certificates (T2) and certificates authorising treatment (T3) under the mental health act were recorded appropriately, with the correct documentation in place.

Any person who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the records.

Rights and restrictions

Nithsdale Ward operated a locked door on entry only; egress was controlled via a push button.

On the day of the visit there were no patients on continuous interventions, two patients were on enhanced interventions.

All individuals admitted to Nithsdale Ward have the right to advocacy services. This service was available on the ward and staff ensured that individuals who wished to have access to advocacy had the contact details for the local service.

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 patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. We reviewed any individual who was subject to a specified person restriction.

For one person we noted there was no specified person paperwork completed in relation to this; items had been removed and withheld without the correct legal authority. The senior charge nurse contacted the Responsible Medical Officer (RMO) to discuss this matter. We advised that these restrictions should be withdrawn as the legal paperwork had not been completed at the time, highlighting that this paperwork could not be retrospectively applied. We also discussed that people should be advised of their right to challenge any of the restrictions associated with being a specified person.

The Commission has produced good practice guidance on specified persons[1].

Recommendation 1:
Managers should ensure that specified person status has in place the required paperwork. This should be competently completed at the time thus affording the patient their legal rights. Paperwork should be sent to the Commission timeously.

Recommendation 2:
Managers should consider MDT training in the application and use of specified persons.

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. For the individuals who were on the ward on the day of the visit, we did not find any advance statements on file.

The Commission has developed *Rights in Mind.*[2] 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

On our last visit, we commented on the wide range of choice and availability of activity and occupational therapy (OT) that was available. We are pleased to find that this has continued with OT services providing a range of meaningful group-based, and one-to-one activities. Other activities we heard about were cycling, relaxation, art, games and walking groups.

The Commission notes the need for individuals to have access to meaningful activities which should include creative and leisure activities, exercise, selfcare and community-based activities; it is a vital component in providing safe, recovery-focussed inpatient mental health care. We discussed the input from psychology services and were told about the low-intensity psychological therapies group work and individual input that was available.

We heard positive feedback from both individuals and staff about 'Let's Get Sporty' with an independent sector service. This is a social enterprise, not for profit service that visits the ward twice a week. They offer a variety of physical activities and sports for the individuals.

[1] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512
[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

When clinical activity allows, the nursing staff also support social trips and access to the gym in the evening.

The physical environment

Nithsdale Ward is located on the first floor of Midpark Hospital. There was lift access to the first floor. The ward was bright, well-presented and well maintained.

Individuals are accommodated in single rooms with en-suite toilet and shower facilities. There are several rooms available in the ward for visits/meetings.

We heard about a fire that had occurred in the ward earlier in the year and of the impact that this had on both individuals and staff team. The damage to one of the bedrooms was so extensive that it could not be used. We were shown the room and the renovation had nearly finished. Staff were hopeful they will be able to use this room again in the near future.

Any other comments

In May 2022, Nithsdale Ward successfully won a bid to be part of the Scottish Patient Safety Programme (SPSP) Mental Health Improvement Collaborative. The aim of the collaborative is to ensure 'everyone in adult mental health inpatient wards experiences high quality, safe and person-centred care every time. The primary area of improvement for Nithsdale Ward was putting the *From Observation to Intervention* guidance into practice.

Service design and quality improvement approaches were used. The service had already made changes to culture and practice, driven by leadership, and based on the principles of the SPSP Observation to Intervention Guidance.

The aim of our project was to systematize and improve what we were doing by developing a system and process for a clinical pause. This would identify the deteriorating patient at risk of harm and enable the scaling up and down of meaningful and person-centred interventions.

A clinical pause template and guidance was developed. Key areas include description of deterioration/concerns, professionals involved in the clinical pause, mental health assessment, patient's views, carer/relative views, level of intervention outcome (general, enhanced, or continuous), and a summary of a least restrictive safety plan and agreed criteria for scaling up and down. This has enabled the service to embed a continuum-based intervention approach on the ward that has replaced surveillance like practice and enabled them to meet the needs of patients and manage risk in a way that is flexible and person-centred.

The results suggest that they are now identifying patients requiring increased support and meeting their needs in a way that is person-centred, with scaling up and down of meaningful interventions.

On the day of our visit, we heard about the implementation of ‘continuous interventions’ on the ward and the positive impact on both staff and individuals. We were told that this now ensured that the individual was involved in the process throughout, identifying strengths and protective factors, asking the individual what helped to reduce their stress and collaboratively writing and devising the safety plan. One individual commented that it she “felt safe on the ward”.

Our end of day discussion focused on the project and its positive impact on both individuals and the clinical team. The senior managers told us that they are in the process of developing a protocol and local policy and plan to implement this approach with the wider service.

Summary of recommendations

Recommendation 1:
Managers should ensure that specified person status has in place the required paperwork. This should be competently completed at the time thus affording the patient their legal rights. Paperwork should be sent to the Commission timeously.

Recommendation 2:
Managers should consider MDT training in the application and use of specified persons.

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