Mental Welfare Commission for Scotland

Report on unannounced visit to: Midpark Hospital, Balcary Ward, Bankend Road Dumfries, DG14TN

Date of visit: 11 March 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

The Intensive Psychiatric Care Unit (IPCU) is a six-bedded, mixed-sex, purpose-built facility in Midpark hospital. An IPCU provides intensive treatment to individual who may present with an increased level of clinical risk and may require an enhanced level of observation.

IPCUs have a higher ratio of staff to patients and a locked door. It would be expected that staff working in IPCUs have specific skills and experience in caring for acutely ill and often distressed patients.

On the day of our visit, all six of the beds were occupied. We last visited this service in October 2023 and we made two recommendations regarding the environment, relating to a storage issue and the use of an activity room as a bedroom. We were pleased to note on the day of this visit that both matters had been addressed and resolved.

On the day of this unannounced visit, we planned to meet with individuals and speak with their relatives. We wanted to check the progress on several individuals who found themselves in IPCU longer than six months. We wanted to hear from staff about the care and treatment they were delivering to patients and how they ensured that care and treatment was being provided in line with mental health legislation and in a human rights compliant model.

Who we met with

We met with five individuals and reviewed the electronic care records of these individuals. As this visit was an unannounced visit, we were unable to meet with any carers or relatives.

We spoke with the senior charge nurse (SCN), the charge nurse, the junior doctor, various nursing staff and the service manager.

In addition to meeting with the staff team, we had the opportunity to observe individuals taking part in ward-based activities.

Commission visitors

Mary Hattie McLean, nursing officer

Mary Leroy, nursing officer

What people told us and what we found

We attempted to meet with a number of individuals, however they were noticeably unwell and subject to active interventions. Due to the extent of their mental health symptoms, some of the individuals were too unwell to express their views on their care and treatment.

However, some individuals were able to tell us of their experience during their admission to the service; they told us they felt safe and welcomed to the ward. We heard positive comments including “staff are approachable, they are helpful especially when it is difficult for me”. Another person said they felt that “the staff do a good job; they listen to me”; another commented “things are going well for me and the ward feels much calmer”.

While individuals accepted that Balcary Ward required restrictions to be in place due to safety and risks, there were also themes raised with Commission staff about feelings of boredom and a lack of structured activity. For one person, we heard that they had a lack of time off the ward but we understand from the nursing staff that this is due to legal restrictions.

All the staff members we spoke with knew the individuals on the ward well. They were able to comment on any risks, restrictions and management plans that were in place to support the patients. The care we observed being delivered on the day of our visit appeared to be personalised and focussed on the individual’s care plan goals. We were concerned to hear that delayed discharges could at times impact on a person’s progress towards recovery.

We heard from the senior team about challenges with “patient flow” throughout the service, commenting that some patients were waiting for placements and others were at early stages of discharge.

For three patients the plan was to discharge them to a community placement and the other two patients were to be transferred back to an adult acute admission service.

The SCN also raised the implications that this lack of progress with discharge could have on the patient “ flow” and when an individual in an adult acute service bed may need “intensive care due to the patient being acutely unwell and require a secure environment for intensive treatment”. He described “the team had to prioritize risk, and this may cause a delay in the patient accessing the appropriate care”.

We also heard about how the service were proactively attempting to manage this matter by offering “in reach support” to the adult acute admission wards. Assisting the team in the adult acute wards with the management of risk, observation and intervention.

There was a discussion with the Commission staff about the complexity of the clinical presentation of some individuals and that this involved carefully timed planning to ensure that the discharge from the service involved a robust aftercare plan, risk assessment and a suitable care placement.

Care, treatment, support, and participation

Individuals admitted to the ward required an assessment based upon their mental health, physical wellbeing and risks. The assessment process informed the nursing care and interventions that an individual required. Nursing care plans were held on the new digital platform "Morse."

We found the nursing care plans to be person-centred. They opened with information from the patient about what was important to them and what would support them to achieve this, with consideration being given initially to some short-term goals as well as longer-term goals. This approach ensured that the care plans focussed on the individual's strengths and protective factors. This component of care planning also supported and evidenced the individual's involvement in the care plan process.

We were pleased to hear people were actively encouraged to participate in all aspects of their admission, ranging from information gathered from the initial assessment to participation in care planning and attendance at multidisciplinary team (MDT) meetings, as well as active participation in their discharge planning.

We found that care plans were reviewed and regularly updated. The reviews were linked with the care plans, they were thoughtful and detailed the progress and changes in the individuals' care.

Care records

Information and care records for care and treatment held on Morse was easy to navigate. There was a clear focus on an individual's mental health and wellbeing, with a range of completed physical health assessments.

Individuals admitted to Balcary Ward required assessment based upon their level of individual risk which for a variety of reasons could not be safely managed in the general adult mental health ward. We were pleased to see that the risk assessments were reviewed regularly and updated as necessary.

Multidisciplinary team (MDT)

The multidisciplinary team consisted of psychiatry nursing staff, occupational therapy staff and pharmacy. Referral to psychology, physiotherapy and dietetics took place as and when required.

The MDT template highlighted who attended the meeting. We noted that the MDT documentation was of a good standard; it was informative and there was a clear action plan that identified outcomes and actions for the individuals' care goals.

The meeting take place weekly, and we were told by staff that both patients and families and carers were invited to attend.

Use of mental health and incapacity legislation

On the day of our visit, all six individuals in the IPCU were detained under Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act,1995. The appropriate detention paperwork was readily available.

We heard directly from some individuals that they were aware of their rights in relation to the orders to which they were subject. This included easy access to advocacy and there were some individuals who were able to tell us about their access to, and input from, a solicitor to represent them at previous or forthcoming mental health tribunal hearings.

Part 16 of the Mental Health Act sets out conditions under which treatment may be given to detained patients, who are 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 when required. However, we found errors where medications had been prescribed and administered but were not recorded on the respective certificates. We raised this with senior managers on the day and were informed they would attend to this as a matter of urgency.

Recommendation 1:
Managers must identify a robust system of auditing consent to treatment forms to ensure any errors are immediately rectified so that treatment given and/or received is legally authorised.

There was one person who was subject to guardianship order under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act). We accessed a copy of the powers granted and the proxy decision maker had been consulted appropriately.

Rights and restrictions

On the day of the visit there were three individuals who required additional support though continuous interventions from the nursing staff. We were told that individuals who were subject to those measures were reviewed daily.

The design of the Balcary Ward IPCU meets the national standards for intensive care locked wards, supporting people with risks who require a lower level of security.

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. On the day of the visit, there were no individual who required these levels of restriction.

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 found one individual had an advance statement.

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

There is a need for individuals to have access to "meaningful activities" which should include creative and leisure activities, exercise, selfcare and if appropriate community access. It is a vital component in providing safe, recovery focussed inpatient mental health care.

We heard from individuals and staff in the ward regarding a variety of activities that were available including art and crafts, listening and playing music and access to the local gym. We also heard that the occupational therapy service ran groups and one-to-one sessions, including arts and crafts, cooking groups and quizzes.

The physical environment

Midpark is a relatively new hospital that opened approximately 14 years ago. Balcary Ward was purpose-built for individuals who would require intensive care for their mental health needs.

Balcary Ward provides a pleasant environment, with six single rooms that have en-suite facilities. There is access to communal areas that were well maintained. We saw several people making use of the garden to exercise and get some fresh air.

We also visited the gym, which is out with Balcary Ward and shared with the other wards on the site. We heard that new equipment had been recently purchased.

When walking around the ward to review the environment, we noted that in the main office there was a whiteboard with individuals' names, their legal status and various additional other information recorded for staff. This board was visible through the main window of the office, where other patients and visitors could easily see this. The visibility of this information requires to be addressed staff should ensure than an individual's information is kept secure and confidential.

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

Recommendation 2:
Managers, with support from estates staff should ensure that this whiteboard is replaced to ensure that all patient information is always kept secure.

Any other comments

We were pleased to hear from the clinical team about their nomination for the Care and Mental Health Award at the Scotland Health Awards in 2024. We were given information about this project and how it had been integrated into practice and the positive impact this had had on people's care and treatment.

The Balcary team have implemented use of the "Dynamic Appraisal of Situational Aggression Tool (DASA)" which is endorsed by National Institute for Health and Care Excellence (2015). The anticipated benefits of using the DASA tool include an overall reduction in violent and aggressive incidents and incidence of restraint. Prevention of violence depends on both the ability to assess a person's potential for aggression and interventions to reduce or mitigate the risk. Using this recognised tool demonstrates greater predictive ability than clinical judgement alone. The DASA tool allows clinicians to identify high risk patients for early intervention and improved risk management.

Through further collaboration with those in the ward and the OT team, a DASA protocol, interest checklist and activity planner have been developed that outline risk specific, person-centred, structured activities and targeted clinical interventions for those with complex and challenging needs.

The team have implemented structured meaningful activities with individuals by commencing an OT led group once per week, based around sensory input which is flexible, graded and adapted to meet individual needs.

Nursing staff have supported and engaged with maintaining the meaningful activity programme out with OT times, meeting the preferences of those in the ward. All of this has been incorporated into the individual's care plans.

Initial findings from the joint work have noted a sustained reduction, particularly in incidence of challenging behaviours, with a 52% decrease in number of incidents, a 25% reduction in aggression and violence and a 61% reduction in episodes of restraint. The project has successfully evidenced a reduction in the incidence of violence, aggression and restraint in the IPCU.

The service will continue to introduce this approach into practice and is looking to implement the DASA model across the appropriate services in the hospital.

Summary of recommendations

Recommendation 1:
Managers must identify a robust system of auditing consent to treatment forms to ensure any errors are immediately rectified so that treatment given and/or received is legally authorised.

Recommendation 2:
Managers, with support from estates staff should ensure that this whiteboard is replaced to ensure that all patient information is always kept secure.

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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