Mental Welfare Commission for Scotland

Report on announced visit to: Midpark Hospital, Glencairn Ward, Bankhead Road, Dumfries DG14TN

Date of visit: 29 April 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

Glencairn Ward is a 15-bedded acute assessment unit that provides care and treatment for older adults.

On the day of our visit, there were 15 people on the ward and no vacant beds.

We last visited this service in February 2022 on an announced visit and we made recommendations on the recording, storage and accessibility of all documentation. We were pleased to note on the day of our visit that the recommendation had been addressed and resolved.

We wanted to hear from staff about the care and treatment they were delivering to individuals ensure 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 and reviewed the care notes of six patients. We also spoke with three relatives.

We spoke with the service manager, the senior charge nurse (SCN), the charge nurse and other nurses who were on duty on the day of the visit. We spoke with both consultant psychiatrists and the local volunteer for the service.

We also 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

Some people were able to tell us of their experience during their admission to the service. They told us they felt safe and welcomed on the ward. We heard comments from a number of people that were positive about their experience of care.

One person told us that “the staff look after me very well and are always willing to help me with anything I need”. Another commented on how approachable the medical staff were, saying ”they always listen”. For some of the people we met with, they commented on the “good quality of the food” that was available in the ward.

The individuals and relatives that we spoke with were positive about the value of the multidisciplinary approach with their care and treatment, praising the input from psychology, occupational therapist and the volunteer service, telling us how they had benefitted from these members of the team and how they valued this.

We heard positive comments from relatives including “the excellent leadership” and that “the ward is a breath of fresh air; my relative has the best person-centred care that they can have”.

Other relatives commented on the informal support that was available to them, advising us that “the nursing staff are always welcoming. They make themselves readily available to meet with us and update us on our relative’s care and treatment”.

The staff team described how “closely they worked with families and how they ensured families were involved in the person’s care”. Glencairn ward staff actively seek family and carer feedback through a range of methods including care assurance which supports to identify areas to improve communication and engagement.

On the day of the visit, we met with a committed and enthusiastic team who were keen to progress improvements and developments in their service. There was a focus on ensuring that the individual was at the core of the care that was delivered. One nurse spoke about how motivated the staff team were, and how much they enjoyed working on the ward.

The SCN fostered a supportive and collaborative environment for both staff and patients. The SCN ensured that the staff members felt empowered to meet the goals that were set to improve care and patient outcomes.

We heard from the leadership team that there was a focus on capacity and capability. We discussed the challenges that can occur if capacity issues go unaddressed and the need for assessment, knowledge, skills and the tools that the team require to deliver on their goals. The team were at the early stages of assessment and looking at individual leaders’ particular strengths and skills.

We look forward to hearing how this project develops and importantly the impact on improvement to patient care.

Care, treatment, support, and participation

We found nursing care plans to be person-centred. They opened with information from the individual, indicating “what is important” and “what matters to me documentation”. This allowed the individual to set their own goals and also ensured that the person’s care plans focused on strengths and protective factors. This component of care planning also supported and evidenced the individuals’ involvement in the care planning process.

There was focus on mental health and wellbeing, with physical health assessments completed for those whose care we reviewed and who had physical health comorbidities. We found that physical health care needs were considered and well documented in the care records.

We found that care plans were reviewed and regularly updated. The reviews were linked with care plans, were meaningful and detailed any challenges and progress in each individual’s care.

We heard that the service is continuing to embed the Newcastle model, a person-centred approach that is used to understand and manage stress and distress for the individual. The model includes assessment, formulation, care planning and review. This structured approach help ed everyone to understand the individual’s presenting behaviours and with the development of personalised care plans

The ward-based team valued the input from their colleagues in psychology, specifically with the Newcastle model and we could see how this had assisted with the management of stress and distress. This model of care and treatment has been embedded into the ward’s philosophy and had been welcomed by staff, the individuals and their relatives.

We also heard about the input from psychology services with staff supervision. We were told of its benefits in enhancing professional development, in improving patient outcomes and that it could promote a safe space for learning and growth.

On review of the risk assessments, we found that the information provided comprehensive, person-centred information regarding the individual’s risk. We reviewed where restrictions were put in place for individuals and were satisfied that where restrictions were imposed, they were commensurate with the risk assessments that were in place.

There were excellent examples of anticipatory care plans. These were mainly used to support those who had long term physical health conditions and helped in planning for unexpected changes with these. The plans evidenced conversations,

collaborative interactions and shared decision-making with individuals, their families and the multidisciplinary team (MDT).

Care records
Individual's 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, the outcome of these and what progress had been made.

We found detailed narratives of each person's journey in the chronological notes. We could see when interventions had been identified through assessments, and the accompanying care plans, including multidisciplinary recording of the process.

Multidisciplinary team (MDT)
There were 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 (AHPs) as required.

On the day of the visit, we found that the MDT maintained a focus on person-centred care and treatment, with an emphasis on psychological and physical wellbeing. We found evidence of an approach to treatment that was holistic and personalised.

The MDT template highlighted who attended the meeting. We found the MDT documentation to be of a good standard and it was informative, with a clear action plan that identified the intervention and outcomes for the individual's care goals.

In the template we also found evidence of regular reviews by AHPs, with assessments, actions and outcomes that were required.

The MDT meeting took place weekly and were told that by staff, individuals and their families and carers that they were invited to attend. We saw evidence of this in both the MDT template and in the chronological records.

We heard about joint working with pharmacy and the clinical team in the development of a standard operating procedure (SOP) for the assessment of the individual's ability to self-medicate.

We were heard that the project had focused on the least restrictive option for the patient, where careful consideration was given to potential harm, risks and the individual's compliance. The team told us that there had some early success with the project, following trials that have resulted in some individuals not requiring the level C medication package post discharge. We look forward to hearing how this project progresses on our next visit to the service.

We heard from the senior team about challenges with patients who were deemed fit for discharge and that their discharge was delayed. On the day of the visit there were

five people who had been identified as having their discharge from hospital care delayed. When we reviewed the care records files and in discussion with senior managers, we found that there were difficulties in arranging suitable care home placements and some were awaiting welfare guardianship orders. We heard that for some, the complexity of their presentation required a specialist service to be sought.

We discussed the potential benefits of a service based social worker with the senior team and advised of the potential positive benefits that this could have with enhancing collaborative work between hospital, community services and the local authority. We were advised that this was being discussed and considered by the senior team.

Use of mental health and incapacity legislation

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

Some of the individuals we spoke with understood the legislation and had been made aware of their rights around appeal. For some people, who presented with significant impairment of their cognitive function, understanding their rights and the restrictions that were in place was difficult to understand.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, 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 where required and corresponded to the medication that had been prescribed.

There were seven patient who were subject to a guardianship order under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act). We found copies of the powers granted and noted that the proxy decision maker had been consulted appropriately.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

On the day of the visit we found all section 47 certificates completed, with detailed treatment plans in place.

Rights and restrictions

Section 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 an

individual is made 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 the least restriction is applied. On the day of the visit one person required this intervention and the relevant paperwork was in place.

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 do 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 our visit.

We heard about the local advocacy service that is available to support individuals and that nursing staff can initiate referrals on behalf of the individuals in the ward. We were advised that advocacy services visit weekly and that they are flexible in terms of offering appointments and in meeting people to discuss their rights and provide support to help them express their views.

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

Individuals should have access to "meaningful activities" which can include creative and leisure activities, exercise, self-care and if appropriate, community access. It is a vital component in providing safe, recovery-focussed, inpatient mental health care.

In Glencairn, activities are considered to be everyone's responsibility. This includes the nursing team, as well as direct involvement and support from psychology, occupational therapy and a ward volunteer.

The ward-based team recognised the value of having a programme of activities available as an investment to maintain skills. On the day of the visit, a number of individuals were participating in a baking group which they appeared to be enjoying.

We heard about the benefits of the ward volunteer and met with them to discuss this role. The volunteer spends an agreed amount of time on the ward, offering informal interactions and small, structured groups. The volunteer offers their time, out with but complementary to the professional interventions. On the day of the visit, we were told by patients and staff about the benefits of this role. The SCN advised us that there were plans in the team to expand this role and they were at an early stage of

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

negotiation and development in seeking another volunteer. We look forward to hearing about further development of this.

We were told about input from AHPs and of the low-intensity psychological group work that has focussed on anxiety, problem solving and sleep.

We also heard about the “let’s get sporty” group. This organisation had only recently commenced with their input and visit the ward once a week. They offer people the opportunity for both physical exercise and sports.

The physical environment

Glencairn Ward offers a pleasant and homely environment. Individuals are accommodated in single rooms with ensuite toilet and shower facilities.

There are several rooms available in the ward for visits and meetings.

There are two gardens that can be accessed although one of the gardens is shared with the ward next door. We were told that finances have been secured and there were plans to renovate and redesign this garden space.

The second garden is accessible and used only by individuals on Glencairn Ward. We were told about a recent issue in relation to the maintenance of the garden, and that the grass in this garden was not being cut regularly. This maintenance was not occurring due to financial savings. This was of concern, and we discussed with senior managers the impact on both patient safety and the loss of this therapeutic area for those who used this space.

Recommendation 1:
Managers should ensure that the garden area provides a safe, pleasant and easily accessible environment for individuals, visitors and the staff team.

Good practice

We heard from staff about the introduction of ‘the coaching model’ that has been implemented on Glencairn Ward as part of a national pilot; this is now part of the culture in the ward due to the unexpected wins from the project,

The coaching model allows the learner to lead on patient care and take more responsibility for their learning, allowing the learner to unlock their potential and improve their own performance by identifying goals and objectives. They receive guidance from the coach rather than direction from the practice assessor or supervisor. Questions are used as opposed to instructions which allows the learner to explore options and identify priorities.

Some of the benefits and wins for those using this model is that for learners there can be a higher performance in interview, increased confidence and competence.

Staff who are learning from this model also experienced better communication skills, emotional safety and resilience .

The team have observed a number of improvements with patient care, with the outcomes of care, improved discharge processes, and less use of “as and when required” medication.

Improvements for the organisation have been in quality improvements in care and in an improved working environment. An example of this was the ‘ripple effect’ in the multidisciplinary team where there has been evidenced improvements with innovation and creativity.

The “wins“ have been that there is the potential for wider organisational benefit if this coaching model was to be rolled out across the board. The clinical team were positive about the impact that this project has had on Glencairn Ward.

Summary of recommendations

Recommendation 1:
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.

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