Mental Welfare Commission for Scotland

Report on announced visit to: Cree Ward, Midpark Hospital, Bankend Road, Dumfries, DG14TN

Date of visit: 24 June 2026

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

Cree Ward is a 16-bedded unit, situated in the grounds of Midpark Hospital. It is a specialist acute assessment unit for people with actual or suspected cognitive impairment because of dementia. The ward is a mixed-sex facility and supports individuals from all localities in Dumfries and Galloway for inpatient assessment and treatment. On the day of this visit, there were 13 individuals in the ward

We last visited this service in July 2024 as an announced visit and made two recommendations regarding the provision and recording of activities.

Who we met with

We met with seven people and undertook a detailed review of the care records for five of those that we met with. We also met with two relatives who were visiting the ward on the day of our visit, and who had asked to meet with us.

We had the opportunity to speak with a range of staff who were part of the care team. We spoke with the service manager, two charge nurses, the consultant psychiatrist, the pharmacist, and several members of the nursing team.

This provided us with a good overview of the service delivery in the ward.

Commission visitors

Mark Richards, nursing officer

Gemma McGuire, social work officer

What people told us and what we found

During our visit to Cree Ward, we met with both charge nurses for the ward who discussed with us the vision for the service and shared the developments and improvements that have been implemented since our last visit in 2024.

We met with an enthusiastic, knowledgeable, and committed staff group who were focused on the delivery of high-quality, person-centred care. They recognised the importance of relatives and carers as part of the therapeutic alliance. All of the staff we met with were motivated, talked about how they enjoyed working in the ward, and being part of the Cree Ward team. They all expressed pride in the work that they did. They confidently and capably answered all queries that we had on the day.

We observed staff engaging with individuals throughout the day of our visit in a warm, compassionate, and caring manner.

We met with several individuals on the day, although most struggled to offer detailed verbal feedback on how they felt about the care and treatment they were receiving; this was due to the level of cognitive impairment they were experiencing. One individual was able to discuss her experience of the ward commenting “it’s good here and the staff look after me.” Another individual described having good contact with her family who were due to visit that day. Another individual commented that ‘they are nice here’ while another stated that they were ‘fed up.’

One relative talked about how they found the staff helpful and approachable, and how well supported they felt. They said, ‘I was lost, with no idea what to do, but was immediately offered information and support when my husband was admitted, including details about guardianship.’ Another offered positive feedback about their connection with the multidisciplinary team (MDT), appreciating the proactive communication from different disciplines when changes were being made to care plans and care delivery.

We saw good evidence of the implementation of the triangle of care; a model of working collaboratively between the individual, professional, and the carer. The model supports safety, recovery and sustains wellbeing.

In the chronological notes we saw evidence of excellent communication between family and proxy decision makers. In the MDT minutes, there was evidence of family attendance and involvement in the individual’s meetings. For some families, where there had been recent diagnosis, there was evidence of supportive communication, or counselling should the family wish to access and engage in this.

Care, treatment, support, and participation

Having spoken with individuals and relatives, we reviewed records of care in the ward. NHS Dumfries and Galloway use the MORSE electronic patient record system in Midpark Hospital. We found this system easy to navigate.

We reviewed a variety of clinical assessments, risk assessments and care plans. We found these to be comprehensive, strengths-based and were written from the perspective of the individual. All the care plans we reviewed were up-to-date and we could see that they had been reviewed regularly. We could easily see the connection between assessments, care planning, discussion and decision making at the MDT. We found all care plans to be of a particularly good standard with a clear focus on mental health and physical wellbeing.

'Getting to know me' and 'what matters to me' documentation was comprehensive.

We also found relevant life history information to be well documented in initial assessments and in the formulation component of the Newcastle model.

The Newcastle model is a person-centred psychological framework used in dementia care to understand and manage challenging behaviours. The use of this is now well embedded in Cree Ward with everyone having a personalised formulation and management plan. Nursing staff were able to describe the benefits of this model and how it was central to care planning and delivery.

We reviewed the files of some individuals who experienced stress and distress, and where the Newcastle model was being used. We found detailed formulations along with the care plans for managing behaviours associated with stress and distress, as well as clear information on what may 'trigger' the individual, and the interventions and strategies that would support the person.

The modified Sainsbury Centre risk assessment tool was in use and had been completed for each individual. We noted that this is a generic mental health risk assessment tool that is in use across NHS Dumfries and Galloway but has limited utility as it was not originally designed for people with dementia.

We heard from the charge nurses, a consultant, a pharmacist and from a relative about the use of artificial intelligence (AI) in helping manage pain. This has been introduced as part of a local improvement project and involves the use of an iPad to scan a person's face and from this, make an assessment of whether a person with dementia is experiencing pain, and if this is mild, moderate of severe. We heard that the scores from this AI assessment were used to inform decision making, and we heard from one relative about how impactful this had been in helping to rationalise the pain medication her mother had been receiving and how this had subsequently improved her quality of life.

Care records
Information and care records for care and treatment were held on MORSE which was easy to navigate. Records were updated at least once per shift, and on a multiprofessional basis.

There was a clear and comprehensive focus on an individual's mental health and wellbeing and also evidence of a range of physical health assessments that had been completed and were relevant to the care delivery setting. There was evidence of timely initial assessment and of regular updates across all records that we reviewed.

In our 2024 visit, we made a recommendation to improve recording as it related to the delivery of activities. We could see that this has been addressed, with recording of when activity had been delivered, and also when activity had been offered but declined, with a rationale included when this was the case.

Multidisciplinary team (MDT)
Cree Ward has regular input from psychiatry, psychology, occupational therapy, pharmacy Other allied health professionals were reported as being available on a referral basis. Social work does not form part of the core ward MDT but are still actively involved.

There was very good evidence of regular MDT meetings with attendance from the team adjusted depending on the needs of the individual patient. Families were also invited to join the MDT discussions monthly. We were pleased to see that the MDT meetings notes were detailed and included updates from all professionals. The template also ensured that the actions and outcomes were also clearly recorded.

Staff advised that relatives were routinely invited to the MDT. This was confirmed by the relatives who met with us, and we could also see this in the MDT records. Although the views of relatives were routinely recorded, we did think that the recording could be more comprehensive to help maximise the benefit of collaboration between the individual, their relatives, and the MDT.

On the day of the visit, we explored any concerns relating to individuals remaining in hospital when they were considered fit for discharge. There were five individuals in the service whose discharge was delayed. The MDT meetings and chronological notes documented that delays were being actively addressed by the clinical team with health and social care partners and we heard positive feedback about the role of the 'flow co-ordinator' who attends the MDT meeting. The staff we spoke with had a good understanding of the factors affecting timely discharge, with a lack local care home capacity being reported as a significant challenge.

We were told that on a weekly basis, the service manager chairs a delayed discharge meeting. There is representation from all wards with people who are affected by delayed discharge, along with occupational therapy, social work managers, the community waiting times team, community mental health teams, crisis team, and patient flow co-ordinators.

We also heard about an improvement project being run with Healthcare Improvement Scotland in the ward next door which has reduced delayed discharges by almost 50%, and that this work had now started on Cree Ward. We look forward to hearing how this work progresses in due course.

Use of mental health and incapacity legislation

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

There were two individuals on compulsory treatment orders who had a certificate authorising treatment in place (T3) under the Mental Health Act. This was recorded appropriately with the correct documentation in place.

Where individuals were granted a Power of Attorney (POA) or where there was a guardianship order under the Adults with Incapacity (Scotland), 2000 Act (the AWI Act), a copy of the powers granted should be held in the care records, and the proxy decision maker consulted appropriately; we found paperwork for POAs and welfare guardianship orders. The information was recorded and flagged as alerts in the individuals' electronic files. Throughout the chronological notes we also found evidence of contact with the proxy decision makers.

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 follows the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We found section 47 certificates for all the individuals that we reviewed and where a proxy decision maker was appointed, they had been consulted.

We did find that one individual's partner had signed for consent to share information but there were no powers in place to do so. This was highlighted on the day.

Rights and restrictions

Cree Ward continues to operate a locked door, commensurate with the level of risks identified with the patient group. There was a locked door policy in place and available to all visitors entering the ward**.**

We reviewed individual restrictions on individuals and were satisfied that restrictions imposed were commensurate with the risk assessments that were in place.

The ward has access to advocacy, and details of the service were on display on notice boards at the front entrance to the ward. No individuals were designated as specified persons under the Mental Health Act.

On the day of our visit, we met with and reviewed the care records where we noted that there had been one individual who was admitted on an informal basis and been assessed as lacking capacity to make welfare and financial decisions. We heard how the individual regularly expressed a wish to leave the ward. We were informed that an application for welfare guardianship was being progressed and the care records demonstrated that staff were using individualised interventions to support the person, however it was not always clear what MDT discussion and review had taken place in response to these requests.

During the visit, we discussed this scenario with the service and were advised that staff use a range of individualised strategies, including distraction techniques centred on the person's interests and hobbies, providing activities they enjoyed, and offering one-to-one therapeutic engagement.

We were also advised that the need for legal safeguards is reviewed and discussed weekly by the MDT, including consideration of whether the criteria for detention under the Mental Health Act would be met.

We advised the service that discussions regarding this approach to care should be clearly recorded in an individual’s care record, including the MDT documentation, to evidence that an individual's rights, legal status, and any requirement for legal authority are being actively considered and reviewed.

When we were reviewing the care records, we also noted that there was documentation signed by a relative providing consent for the individual's personal information to be shared with them. Care records confirmed that the individual lacked capacity to provide this consent, although an application for welfare guardianship was being progressed and the individual's past wishes suggested they would likely have agreed.

There was, however, no legal authority in place at the time the document was signed which would enable the relative to provide such consent on the person's behalf. We advised the service to ensure that appropriate legal authority was in place whenever

consent is sought from another person on behalf of an adult who has been assessed as lacking capacity to make the relevant decision. We will review progress in this area of practice during our next visit.

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.

The Commission's *Carers, consent, and confidentiality* has been designed to help family members and carers understand consent, capacity, and confidentiality, and also designed to inform health, social work, and social care professionals when considering confidentiality and sharing information, hearing from families and carers, and listening to what they have to say.

Activity and occupation

Access to therapeutic and recreational activities as part of mental health care and treatment is important. In our 2024 visit report, we recommended that managers should progress and consider the provision of an activity co-ordinator for the service. We discussed progress towards this during our visit. We heard that while additional funding has not been identified for any new posts, progress has been made to strengthen the range activities that were offered.

It was reported that the occupational therapy service has expanded what they offer, and we could see evidence of this in the care records. We found evidence of functional assessments, preparation for discharge plans, and input that included recreational and therapeutic engagement.

We heard that occupational therapy partnered with dietetics colleagues to run the "grub club" every week, with a focus on increasing hydration and nutrition alongside meaningful engagement. They also co-facilitate the 'art matters' programme with Outpost Arts in the main hub area of the hospital twice a month, which those in Cree Ward can attend.

We were advised that a maintenance cognitive stimulation therapy group is now well established and is run every Monday by the occupational therapist. This intervention supports wellbeing and mental stimulation through group activities for people living with dementia.

Staff told us that they have developed options to deliver activity beyond traditional NHS provision and that regular activities were now being delivered in partnership with the third sector. 'Let's Get Sporty' deliver weekly sessions in the ward and these

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

were described as well received. We also heard that the visiting ‘therapet’ dog is very popular too, attending the ward two or three times a week.

We heard that ward staff are actively encouraged and supported to deliver themed activities. The World Cup was a theme when we visited, with the ward decorated in the flags of the competing nations. We also heard that ward staff maintain the curated memory box displays in the day room, which serve as touch points for orientation and initiating conversation.

A new physiotherapy assistant has been recruited who we were told will bring additional focus to physical activity in the ward, and we look forward to hearing more about the impact of this role when we next visit.

When reviewing the chronological notes, we could see when activities were taking place, who had participated, and whether the activities had been beneficial to the individual’s support, care, and treatment. We could also see when activities had been offered and the individual declined, with a rationale recorded for this. This addressed one of recommendations made following our visit in 2024.

The physical environment

Cree Ward offers a pleasant environment with individuals accommodated in single rooms, with en-suite facilities. There is a spacious day room, and when we visited, the door to the enclosed sensory garden was open. The ward was clean, pleasant smelling and appeared well maintained.

There is an enhanced care area which can be used for those individuals who may benefit from care in a separate area, and there is also an activities room situated just off the main day room. There is a separate visiting room which was being used by relatives on the day of our visit.

We were pleased to note that an outside gym had recently been constructed, with this having age-appropriate exercise equipment and which is shared with the ward next door.

The ward also benefits from a ground floor location, with a café area situated just outside the main entrance to the ward. Staff also described the benefits of being located close to the Crichton campus, which is just a short walk from the ward.

Any other comments

We heard from staff from different disciplines about the coaching model that is in place for nursing students. This is a collaborative approach to practice supervision as part of the South of Scotland Coaching Model delivered through Edinburgh Napier University and NHS Dumfries and Galloway. This was reported as having had a positive impact on learning and has led to students having a more meaningful and involved practice placement. We also heard that this has helped influence the wider

culture of care, with greater ‘voice’ from clinical staff at all levels and improved leadership and decision-making skills.

Summary of recommendations

There were no recommendations made from this visit.

Good practice

The use of the AI 'PainChek' platform was reported as making a positive difference to individuals. Staff and relatives discussed that being able to regularly and objectively assess for pain through using a reliable tool has brought additional evidence for decision making by the MDT. We heard of examples where the clinical team were able to safely reduce significant doses of powerful pain-relieving medications with a demonstrable benefit to the overall functioning, safety, and wellbeing of the individual.

Service response to recommendations

While there were no recommendations made for this visit, the Commission would 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 which requires a response within three months of the publication date of this report.

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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