

Mental Welfare Commission for Scotland

Report on an unannounced visit to:

Dalveen Ward, Midpark Hospital, Bankend Road, Dumfries, DG1 4TN.

Date of visit: 30 July 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

Dalveen Ward is a 10-bedded rehabilitation unit situated in the grounds of Midpark Hospital in Dumfries. The unit provides care to people with mental illness and also people with learning disabilities.

There are four beds in the unit whose primary role is to provide individuals, on a multidisciplinary basis, the care and treatment that will identify and support their needs, with a view to helping them towards safe and successful discharge to the community.

There is also an enhanced rehabilitation service with a four-bedded secure unit for people who have a more complex range of needs and associated risk factors, but where there is the same aim of achieving a safe, supported, and positive discharge to a community setting.

Finally, two flats form part of the service and these offer people the opportunity to experience living in their own accommodation while having the security and support from the ward. These flats are in close physical proximity to the ward and offer the opportunity for individuals to start to engage with providers who will support the transition from hospital; they offer the consistency of ongoing support, where required.

On the day of our visit, there were six individuals on the unit, two of whom were in the open rehabilitation area, two in the flatted accommodation, and two in the enhanced rehabilitation area.

We last visited this service in June 2024 as an announced visit and made recommendations on ensuring that that risk assessments were consistent, robust, and accessible, that care plans should be audited to ensure that they fully reflected the individuals' progress towards stated care goals, and that the recording of reviews were consistent across all care plans.

On the day of the visit, we wanted to follow up on the previous recommendations and meet with patients, carers and staff.

Who we met with

We met with, and reviewed the care of six people, two who we met with in person and four who we reviewed the case notes of. We could not meet with any relatives due to the unannounced nature of our visit. We spoke with the service manager, two members of the nursing team and the occupational therapist.

Commission visitors

Mark Richards, nursing officer

Alison Thomson, nursing officer

What people told us and what we found

During our visit to Dalveen Ward, we met with a committed and enthusiastic staff group who expressed hope and pride in the work they do, and who were focused on ensuring that the individual was at the heart of the care they delivered.

All staff appeared highly motivated and were positive about working in the ward. They were able to fully and knowledgeably answer all queries that we had on the day and provided helpful feedback on the services provided. We heard that the ward provided “proper wrap around care but with a focus on building independence” and staff shared stories where a longer-term approach to rehabilitation had led to positive outcomes for individuals with complex needs.

We also heard that communication was “as good as it could be” in and across the various disciplines and that they “worked very well as a team.” We also heard feedback that resources were well matched to meeting the needs of the individuals in the ward.

Individuals that we met with reflected on being involved in their care, treatment, and rehabilitation, and were able to discuss their outcomes and goals. One person stated that they although they did not really like being in Dalveen Ward they rated it as “not 10 stars but ok”. They liked the ward environment, describing it as “peaceful,” talked about being directly involved in their care planning and how staff were “helping make me better.” They also described having lots to do in the ward and that they could leave on escorted passes. Another individual described liking it in the ward and that “they are helping me move on.” The person told us that they did not have a lot of time to speak with us as they had activities planned and advised they are “always busy.”

We were told by senior managers that mental health rehabilitation services have been under review and that they have now completed benchmarking against various best practice documents. The review reported in April 2026 with recommendations to develop a new rehabilitation service that is delivered from the on-site flats, to develop a model of in reach to existing wards, and to redesign the existing unit into a low secure service. They advised us that they are waiting on the outcomes of funding bids to Scottish Government to support them to redesign these services and ensure sustainability. We look forward to hearing more about progress against this in due course.

Care, treatment, support, and participation

Individuals admitted to Dalveen Ward required assessments based upon their mental health, physical wellbeing and risk associated with these.

All the assessments we reviewed were comprehensive, person-centred and were updated to reflect the person's journey towards recovery and discharge from the service. Interactions we observed between staff and patients were positive and professional, and we were pleased to hear that staff were sighted on the neurodevelopmental needs of individuals, as well as needs relating to mental ill health.

The chronological notes that we reviewed provided evidence which detailed how the individual presented on a day-to-day basis, with a record of their participation in varied programmes of activities that had been offered and delivered, and that gave information about times when an individual may have needed higher levels of support.

On our visit to the service in 2024, we made recommendations about clinical risk assessments and care plans. On this occasion we were pleased to see improvement in many aspects of the care plans and that clinical risk assessments were completed for each individual. We heard about the audit process that was in place, and we saw care plans which were person-centred and comprehensive. They were generally of a good standard, with all the care plans having evidence of individuals participating in the process. Care plans opened with the individual identifying their needs and goals, identifying their own strengths, and what interventions and actions were required to aid their rehabilitation.

The Commission has published a [good practice guide on care plans](#)¹. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

We noted, however, that the evaluation of care plans was inconsistent at times. While there was evidence of care plan reviews happening on a regular basis, the evaluations lacked meaningful detail at times, and it was difficult to see what progress was being made towards defined care goals. It is important that the evaluation process adequately details progress and changes in an individual's care, which we did see reflected in some, but not all, of the records we reviewed.

Recommendation 1:

Managers should conduct an audit of care plan reviews to ensure that evaluations consistently and fully detail the patients' progress towards stated care goals across all care plans.

We reviewed the use of clinical risk assessments. The main clinical risk assessment tool used in Dalveen Ward is the Sainsbury clinical risk assessment tool (adapted). On review, we found that this model highlighted and identified risk, had an embedded

¹ *Person-centred care plans good practice guide*: <https://www.mwcscot.org.uk/node/1203>

formulation on risk, and that the risk was reviewed and updated regularly. We noted that this was now embedded in MORSE, the electronic record keeping system, and this addressed a recommendation made following our visit in 2024.

We were advised that all the individuals in Dalveen Ward were managed on the care programme approach (CPA) and could see evidence of this in the clinical record. This approach ensures mental health care is assessed, planned, and reviewed systematically and it helps plan and coordinate the range of treatment, care, risk, and support needs for individuals who have complex care needs. We could see evidence of a comprehensive multidisciplinary and multi-agency contributions to this process and where there was consideration of the identification and management of risk. All this information was readily accessible through MORSE.

Care records

NHS Dumfries and Galloway have adopted the MORSE electronic patient record system for use in Midpark Hospital. The system has been live since early 2024 and is now well-embedded in day-to-day practice. We found that the electronic records for care and treatment were easy to navigate. There was a clear focus on an individual's mental health and wellbeing, and evidence of a range of physical health assessments that had been completed.

The daily continuation notes gave a good overview of the individuals' clinical presentation and their involvement in activities on and off the ward. We were able to see that staff had positive relationships with individuals, and that there was a sense of commitment to providing person-centred care. The language used in the records was inclusive, professional and accessible.

We noted that there were regular entries made in the care records by health care support workers (HCSWs). This was positive as it provided a more direct record of care delivery and a greater depth of perspectives on care. We could see records that were detailed and professionally written, with evidence of regular contact on a one-to-one basis.

There were records where up to three days had passed between an entry being made by a registered nurse and we would encourage the service to consider if there is a minimum frequency for such entries being made.

Multidisciplinary team (MDT)

The ward has a core multidisciplinary team (MDT) consisting of a psychiatrist, nursing staff, and occupational therapy. Other disciplines are involved, as and when needed and there were no unmet needs that were highlighted during our visit. We did hear that social workers were not involved as early as they could be in MDT discussions but that steps were being taken to improve this. We would intend to review this again at our next visit.

Through our review of care records, we saw evidence of regular MDT meetings, with attendance from the MDT depending on the needs of the individual. The MDT meeting template was structured, detailing participation, summaries of clinical discussion, decision making and who was responsible for actioning these decisions.

On the day of the visit, we explored any concerns in relation to individuals remaining in hospital when they were considered ready for discharge from the service. There were three individuals whose discharge was delayed. This represents an improvement on the position noted at our previous visit when there were four delayed discharges. It was positive to hear that service managers are engaging with Healthcare Improvement Scotland on a project to reduce delayed discharges project, and which has shown evidence of reduction in delayed discharges hospital-wide.

The three individuals whose discharge was delayed were under regular review through the MDT meeting. These were all forensic cases awaiting appropriate accommodation/placement and going through the conditional discharge process. We were also told that on a weekly basis, senior managers and the clinical team, including service managers, commissioning services, the delayed discharge coordinator, and the hospital flow coordinator, met to review and agree actions to expedite the process.

This position does, however, remain a cause for concern for those individuals, their relatives, and the clinical team. The MDT meetings and continuation notes had documented that the delays in discharge were actively being addressed, and we also heard about the importance of focusing on proactive discharge planning for all individuals in the ward.

Use of mental health and incapacity legislation

On the day of the visit, all individuals in the ward 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. 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.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 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 required these.

We were told about one individual who was subject to a financial guardianship application. Ward staff were unclear as to what stage this application was at, and we could not see specific reference to this in the clinical records. This was raised with service managers on the day, who agreed to clarify this.

Rights and restrictions

We reviewed individual restrictions and were satisfied that what had been put in place was commensurate with the risk assessment.

There was one individual in the unit who was subject to specified persons regulations. 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 a specified person in relation to those sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised and the need for specific restrictions to be regularly reviewed. With the restrictions we reviewed, we found these had been legally authorised, a reasoned opinion was on file, and we were able to easily access the respective documentation.

All individuals admitted to Dalveen Ward have the right to advocacy services; this service was available, and the ward staff ensured that the individuals had access to contact details for the local service. Individuals and staff told us that advocacy input was highly valued. Information about advocacy services was clearly visible in the ward.

We did not see any advance statements on file for those individuals that we reviewed. We encouraged staff to discuss the making of an advance statement with individuals whose mental health had improved and who were progressing towards discharge.

The Commission has developed [Rights in Mind](https://www.mwscot.org.uk/law-and-rights/rights-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

There was evidence of a range of activities available on site and also activities that could be accessed by individuals in the wider community. Individuals told us they enjoyed the variety of what was on offer and felt that there were sufficient activities to occupy them and to meet their needs.

We found that the service was working to ensure that that each individual was engaging in a range of meaningful rehabilitation-focussed activities, with everyone

² *Rights in Mind*: <https://www.mwscot.org.uk/law-and-rights/rights-mind>

being supported to devise a person-centred weekly activity timetable. We reviewed the individual programmes and noted that there was also information held in the chronological notes on the participation and the outcomes from the activities.

Care plans and continuation notes captured the activities that were offered and what individuals participated in. These were a mix of social, physical, therapeutic, and community outings providing a broad range of opportunities. Activities were provided during the day, evenings, and weekends. Interests were discussed with individuals, informed by interest checklists; weekly planners were developed so that individuals could see the range of what was available each week. Spiritual care was also available in the local community.

We heard that access to community-based activities was aided by the ward having a dedicated pool car, and that the Crichton Campus was an asset that was well utilised for activities, such as the ward walking and cycling groups.

We met with the occupational therapist who worked as part of the core MDT. They described the range of occupational and activity opportunities available on an individual and group basis, both on and off the ward. We also heard about activities provided through third sector organisations such as Outpost Arts. We found evidence of comprehensive occupational therapy assessment, and the assessment and support in the development of life skills, as well as with the preparation for discharge to the community when required.

The physical environment

Dalveen Ward is spacious and clean and was in a good state of repair. On the day of our visit, the ward was quiet and calm and we spoke with a member of the domestic team who was regularly allocated to work on the ward. We noted and commented on the general levels of cleanliness in the ward; it was apparent that they were viewed as important part of the ward team.

All individuals were accommodated in single bedrooms with ensuite facilities and there was access to pleasant, well-kept communal areas. Bedrooms were appropriately personalised.

We had the opportunity to view the kitchen facilities on offer. These are well equipped, had individualised storage and were accessed regularly by individuals in the ward as part of their rehabilitation activities.

There is also access to an enclosed garden. This was landscaped with plants and shrubs and was reasonably well maintained. On the day of the visit, we did not see any individuals enjoying this outdoor space but were assured that it was well utilised. We were told that individuals are keen to help maintain the garden, and they also

have access to a greenhouse, where they grow their own vegetables as part of a gardening group.

The individuals we met on the day commented that they enjoyed the garden space.

Summary of recommendations

Recommendation 1:

Managers should conduct an audit of care plan reviews to ensure that evaluations consistently and fully detail the patients' progress towards stated care goals across all care plans.

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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