Mental Welfare Commission for Scotland

Report on announced visit to: Dalveen Ward, Midpark Hospital, Bankend Road, Dumfries DG1 4TN

Date of visit: 22 February 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

We visited Dalveen Ward in Midpark Hospital, Dumfries. We last visited this resource in February 2018. We were due to revisit in 2020, however our visit was delayed due to Covid-19 restrictions. Dalveen Ward is made up of three specific areas: the rehabilitation unit, the enhanced rehabilitation unit and two self-contained flats adjacent to the ward.

Dalveen Ward activity has also been impacted by the pandemic. We heard that four beds within the ward were utilised as Covid-19 admission beds. We were told that the layout of the ward environment allowed space for the isolation of patients during this admission period. We were pleased to hear that the service has now reverted to its normal remit.

The rehabilitation unit has four beds and the primary role of this service is to work closely with patients on a multidisciplinary basis to identify and support patients' needs, with a view to supporting them towards safe and successful discharge to the community.

The enhanced rehabilitation unit is a four-bed secure unit where patients have a more complex range of needs and associated risk factors, but with the same objective of achieving a safe and positive discharge to a community setting.

Finally, the two flats which form part of the service offer patients the opportunity to experience living in their own accommodation whilst having the security of support from the ward. This also offers an opportunity to begin to work alongside providers who will support the transition from hospital and thereafter a consistency of ongoing support, where required.

There has been considerable impact of Covid-19 restrictions on patients' access to community facing activities, with community links suspended for almost two years at the time of the visit. We are pleased to see some evidence of recovery in this area as restrictions begin to reduce. We look forward to seeing this activity rebuild in the coming months.

Who we met with

On the day of our visit, there were 10 patients in the service. We met with and/or reviewed the care and treatment of six patients. Due to Covid-19 imposed restrictions, we did not have the opportunity to meet with family and/or carers as we normally would and offered times for telephone consultation instead; however, we did not receive any requests for this involvement. We had an opportunity to speak with three nursing staff and the occupational therapy lead for the service.

Commission visitors

Yvonne Bennett, Social Work officer
Mary Leroy, Nursing Officer
Anne Craig, Social Work Officer

What people told us and what we found

The patients we spoke to on the day of our visit were satisfied with the care and treatment they were receiving on Dalveen Ward. The main theme arising from discussion with patients was the level of activity they had within the ward, which they felt could be improved. There was a recognition that Covid-19 restrictions had impacted on their opportunities to access community based activities but they felt that ward activities could also be improved and augmented given the community restrictions.

Care, treatment, support and participation

Having spoken with patients, we reviewed records of care within the ward. We found care plans in need of audit to ensure quality and consistency. Some care plans lacked personalisation which we would have expected to see given the length of admission for this patient group. We also suggest that given the rehabilitation focus of the service, we would have expected more robust reviewing processes. We would expect care plans to reflect progress, identify areas for continuing improvement and tailored to the particular needs of the patient in their preparation for discharge. We were disappointed to see regular reviews which recorded “no change”. It was unclear how care plans were then altered to effect change necessary for discharge.

We did see some evidence of patient involvement in care plans and where appropriate, family/carer involvement too. Overall we saw good evidence of the implementation of the Triangle of Care, a model of working collaboration between the patient, professional and carer which promotes safety, supports recovery and sustains well-being. We heard that normal visiting arrangements which had been restricted during Covid-19 had resumed and this is welcomed by patients and families.

There was evidence of regular multidisciplinary meetings (MDT) with attendance from the full multidisciplinary team, depending on the needs of the individual patient. The quality of the recording of these meetings, which are fundamental to the patient progress, was variable despite a template format in place to record key decisions; we found that these were not routinely completed and referred to electronic records for further information. We discussed this with managers on the day of our visit and heard that the service is imminently due to test an electronic version of the MDT record. We welcome the consistency this should offer and look forward to seeing this development on our next visit.

There remains an ongoing issue in terms of how current recording systems and processes are disjointed and rely on staff accessing a range of electronic platforms and paper files. This has been raised across the service over a prolonged period. Plans to progress a more bespoke system have been hugely delayed as clinical demand over Covid-19 took priority. We are pleased to hear about plans to progress this and hope to see improvements in this area soon. This includes both the quality of care planning processes and the appropriate electronic record of care across the service.

Recommendation 1:

Managers should carry out an audit on the quality of care planning and reviews within the service to ensure it reflects the aims and objectives of the rehabilitation needs of individual patients and records progress towards meeting these.

Use of mental health and incapacity legislation

We reviewed the legal authority for ongoing care and treatment for patients within this service and found all the required statutory paperwork to be in place.

We looked at consent to treatment certificates (T2) and certificates authorising treatment (T3) for all patients who required these and requested the review of one T2 certificate which included intramuscular medication against the Mental Welfare Commission's good practice guide, *Right to treat – delivering physical healthcare*. A link to this guide can be found at: https://www.mwcscot.org.uk/node/509

For some patients who lacked capacity to consent to medical treatment, their care was authorised by a section 47 certificate under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'). We noted in records that use of the AWI Act is often referred to as the patient being "under AWI". This terminology can give rise to some confusion in relation to identifying what legal authority is in place for an individual patient. Being subject to the AWI Act could mean that there is a power of attorney (POA) or that a welfare guardian has been appointed for example. We strongly suggest that services must be specific in records about which specific provision of the AWI Act is relevant to the patient. This is necessary to ensure that there is clarity around existing legal authority for individual patients.

In October 2021, the Mental Welfare Commission published an advice note entitled *The scope and limitations of the use of section 47 of the Adults with Incapacity Act*. This is a useful practice guide which will support a more accurate use of terminology to avoid confusion: https://www.mwcscot.org.uk/node/1638

Rights and restrictions

We reviewed individual restrictions on patients and were satisfied that restrictions imposed were commensurate with a robust risk assessment process which was regularly reviewed within the MDT meetings.

The Commission has developed *Rights in Mind*. This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment. This can be found at https://www.mwcscot.org.uk/rights-in-mind/

Activity and occupation

The level of activity within the ward was the main issue raised by patients on the day of our visit and we had the opportunity to speak with the lead occupational therapist (OT) for the service during our visit. We were advised that recruitment within the OT service had been an issue and that the current allocation of OT services for Midpark was insufficient, which consequently impacted on service delivery. Given the rehabilitation remit of Dalveen Ward, we would expect to see more OT activity in terms of assessment and skills development in preparation for discharge to the community. We fully appreciate the recruitment challenges, however in light of this would ask the service to consider creative solutions e.g., activity coordinator roles on an interim basis, which could ensure activity crucial to rehabilitation is prioritised.

We recognise that activity within the overall service is viewed as being a fundamental part of staff intervention but heard that at times of high clinical need. We were told that staff from Dalveen can be called on to supplement staffing in other areas and this can result in activities reducing as clinical need takes priority. Whilst this is understandable, particularly during the past two years of the pandemic, we would view this as particularly important within a rehabilitation service and as such rehabilitation activities should be protected and promoted.

Covid-19 has impacted significantly on the community links, which have to date played such an important part in preparing patients for discharge. We were pleased to hear that these links are beginning to recover. We look forward to hearing how this is progressing over the coming months.

Recommendation 2:

Managers should consider how the rehabilitation activity within the ward can be increased in light of recruitment challenges within the OT service.

The physical environment

Dalveen Ward offers a pleasant environment with patients accommodated in single rooms with ensuite facilities and access to communal areas which are well maintained.

In addition there is access to kitchen facilities which we saw being used by patients on the day who were preparing and cooking their meals.

Patients have access to an enclosed garden area which has recently had the addition of a canopy to increase the availability of this outside space in less clement weather.

Good practice

During our visit to Dalveen Ward we met with a committed and enthusiastic staff group who were keen to progress developments within their service, despite covering additional shifts for staff absences and redeployment across the wider service.

We were pleased to see the flats attached to the service in use to simulate the experience of independent living with access to support, if required.

Other issues

During the visit we heard how access and availability of community supports was adversely impacting on discharge planning for patients within the service. Whilst this is not just a local issue, we heard about the lack of availability of support staff locally meant that patients who were deemed ready for discharge were required to remain in hospital longer that was deemed necessary. This is a national picture and we will follow this up with the local Health and Social Care Partnership for further information about the extent of this issue and local plans to mitigate delaying discharges wherever possible.

Summary of Recommendations

1. Managers should carry out an audit on the quality of care planning and reviews within the service to ensure it reflects the aims and objectives of the rehabilitation needs of individual patients and records progress towards meeting these.

2. Managers should consider how the rehabilitation activity within the ward can be increased in light of recruitment issues within the OT service.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Suzanne McGuinness
Executive Director (Social Work)

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 individual care, treatment and support is 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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