Mental Welfare Commission for Scotland

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

Date of visit: 4 October 2023

Where we visited

Balcary Ward is a mixed sex, six-bedded intensive psychiatric care unit (IPCU) in Midpark Hospital in Dumfries. An IPCU provides intensive treatment and interventions to patients who present an increased level of clinical risk and require an increased level of observation. IPCUs generally have a higher ratio of staff to patients and a locked door. It would be expected that staff working in IPCUs have particular skills and experience in caring for acutely ill and often distressed patients.

We last visited this ward in February 2022 and made a recommendation about the need for managers to audit the quality and reviews of care plans to ensure consistency and benefit for patients.

Who we met with

Although Balcary Ward is a six-bedded unit, on the day of our visit, there were seven patients in the ward. We met with and reviewed the care and treatment of six patients. We had the opportunity to meet with two relatives on the day of the visit, and on the preceding day we also had phone conversations with a further two relatives.

We also had an opportunity to speak with one of the charge nurses, the senior charge nurse (SCN), and both inpatient service managers.

Commission visitors

Mike Diamond, social work officer

Mary Leroy, nursing officer

What people told us and what we found

Those that we spoke with on the day of the visit told us that overall, they were satisfied with the care and treatment they were receiving on Balcary Ward. On the day, we noticed a calm and relaxed atmosphere, however, one person said that they would like to see more staff present in the IPCU as individuals in the ward had lots of demands, and were sometimes called to other wards to help out. A few of those that we spoke with indicated they would like the occupational therapy staff to have more time in the ward.

There were no patients on continuous interventions or close observation on the day of the visit.

We heard mixed views from the relatives in relation to staff communication, with some telling us that it was very good and others who had the opposite view. Some staff were recognised as they "went the extra mile" and one relative told us the staff had used video calls to help facilitate communication with patients.

Care, treatment, support and participation

We reviewed records of care in the ward and spoke to staff about some of the points raised by patients and relatives.

Since we last visited the ward, it has benefitted from the new electronic records platform, MORSE used to record patient information. On first appearance, this was a very straightforward and fast system that staff are now using to record patient information. We were able to see clear care plans with individualised goals, highlighted in the person's own words at the start, noting what mattered to them; these were also signed by patients. We heard that this was the initial first phase of MORSE and the next one will include risk assessments and other documentation. We were shown current risk assessments that were electronically stored elsewhere on the system. These will all be transferred in due course.

The care plans were personalised and reviewed regularly by the team. A record of attendance at ward reviews was stored in the notes, along with actions that were delegated to specific staff. It was clear that patients were also invited to attend the multidisciplinary meetings (MDT's), as this was documented. The care plans covered both mental and physical wellbeing. On the day of the visit, two responsible medical officers (RMOs) were holding their weekly MDT meeting attended by a complement of staff.

The senior charge nurse was also able to demonstrate the template used to capture the quality and consistency of care planning. Every week a different care plan is audited by managers. We were happy to see the development of this to improve patient care.

Use of mental health and incapacity legislation

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, 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 being prescribed. We found that all T3s had been completed by the responsible medical officer to record non-consent; they were available and up-to-date.

For some patients who lacked capacity to consent to medical treatment, their care was authorised by a section 47 certificate under Adults with Incapacity (Scotland) Act 2000 ('the AWI Act). Some of the patients were also subject to welfare guardianship orders under the AWI Act. We reviewed the relevant paperwork, and staff were clear on which of their patients had such orders.

Rights and restrictions

All of the patients in the ward were subject to compulsory treatment and required to be in a clinical setting that offered intensive care. We reviewed individual restrictions on patients and were satisfied that the restrictions imposed were appropriate following a comprehensive risk assessment process. We saw evidence that this was regularly reviewed in the MDT meetings.

At the time of the visit, none of the patients in the ward were subject to specified person's restrictions.

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/law-and-rights/rights-mind

Activity and occupation

In the individuals' care records, we found activity plans, dependent on each individual's abilities to participate. Some patients were receiving one-to-one activities with the support of nursing staff and occupational therapy staff. There was clear evidence of arts and crafts taking place in the ward.

We were told by relatives of the positive involvement of a third sector provider who was supporting one individual's rehabilitation to the community, to ensure continuity following discharge. This patient's discharge was delayed and will be subject to further monitoring by the Commission.

The physical environment

Midpark is a relatively new hospital opened approximately 11 years ago. Balcary Ward was purpose built for intensive care patients. On the day of the visit, we found that the ward was warm, despite adequate ventilation. An issue arose several times during the day with individual room doors blowing open due to a window being open. This was distracting for patients when being interviewed. This was discussed with staff on the day but they were already well aware of the issue. Balcary Ward offers a pleasant environment with patients accommodated in six single rooms with en-suite facilities and access to communal areas that were well maintained.

We saw several patients making use of the garden, to exercise and get some fresh air. We also visited the gym, which is outwith Balcary Ward and shared with the other wards. It was disappointing to see a hospital bed being stored in the middle of this area. We advised the managers that this bed should be removed and stored in an appropriate area out with the gym.

One of the patients did not have an en-suite bedroom and was being accommodated in one of the activity room/intensive treatment rooms ("surge room"). This patient had to ask staff

to help them access to the locked toilet/shower in the ward. This does not equate to good personalised care and compromises dignity for this patient. We understand there were reduced options at the time of admission but this room should be returned to an activity resource as soon as possible.

Recommendation 1:
Managers should review the use of the activity/intensive treatment room, and operate the IPCU as a six-bedded resource.

Recommendation 2:
The bed being stored in the gym should be removed and stored in an appropriate storage area.

Summary of Recommendations

Recommendation 1:
Managers should review the use of the activity/intensive treatment room, and operate the IPCU as a six-bedded resource.

Recommendation 2:
The bed being stored in the gym should be removed and stored in an appropriate storage area.

Service response to recommendations

The Commission requires a response to this recommendation 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 MWC 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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