Mental Welfare Commission for Scotland

Report on an announced visit to:

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

Date of visit: 6 June 2024

Where we visited

Dalveen Ward is a 10-bedded rehabilitation unit situated in the grounds of Midpark Hospital.

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 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 whilst having the security and support from the ward. This offers the opportunity for individuals to start to engage with providers who will support the transition from hospital and offers the consistency of ongoing support, where required.

On the day of our visit, there were seven individuals on the unit.

We last visited this service in February 2022 as an announced visit and made recommendations on auditing nursing care plans, and the recruitment of an occupational therapist to the service.

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

Who we met with

We met with six individuals and reviewed their care records. We also met with one relative and a named person.

We spoke with the service manager, operational manager, the senior charge nurse, consultant psychiatrist, occupational therapist and several members of the nursing team.

Commission visitors.

Mary Leroy nursing officer

Margo Fyfe, senior manager, west team

What people told us and what we found

During our visit to Dalveen Ward, we met with a committed and enthusiastic staff group who were keen to progress developments in their service and who held the individual at the core of the delivery of their care. Nursing staff were motivated and told us that they enjoying working in the ward; they were able to knowledgably answer all queries that we had on the day.

Some staff members wanted to meet with us on the day and provided feedback on the service. They described the staff team as "continually promoting independence for their patients". One person commented "there is good leadership, and the management team are approachable and supportive". Another individual commented that the team "work well together, many of us have worked in the service for some years, and the staff team is consistent and caring".

A relative stated that "the service is fantastic; there are lots of opportunities for patients, and the staff team know their patients well".

Individuals that we met with reflected on feeling involved in their care and treatment and rehabilitation, and they were able to discuss their outcomes and goals. Some individuals told us about up-and-coming plans related to their care journey in the rehabilitation service.

We were told by senior managers that they are in the early stages of reviewing the rehabilitation services in the hospital; this will involve benchmarking the service against national rehabilitation standards. Following this report, the service will look at reconfiguring the local services.

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 of the assessments we reviewed were comprehensive**,** person**-**centred and were updated to reflect the patient's journey to recovery and discharge from the service.

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 a varied programme of activities that had been provided in the ward, and that gave information about days when an individual may have needed higher levels of support.

On our previous visit to the service, we made a recommendation about nursing care plans. On this occasion we were pleased to see improvement in some aspects of the nursing care plans. We heard about the audit process that was in place, and for many of the individuals, nursing care plans were holistic. They were of a good standard, with several of the care plans having evidence of individuals participating in the process. Care plans opened with the individual identifying their needs and goals, and interventions required to aid their rehabilitation.

However, we noted that the review process was inconsistent. There was a clear process of care plan reviews happening, but this process did not always relate to individual care plans, more specifically, the "identified needs and goals" section in the care plans. It is vital that the review process is thoughtful and meaningful, and that it details progress and changes in patient care.

We reviewed the risk assessments. One of the clinical risk assessment tools used in mental health services is the Sainsbury clinical risk assessment tool (adapted). For some individuals, in the service, this model was being used. On review, we found that this model highlighted and identified risk, had an embedded formulation on risk, and the risk was reviewed and updated regularly. However, although the risk assessment was updated, it was difficult to quickly identify what the current risk was, and there was no supporting treatment/care plan to identify what actions were being taken to address the risk.

Senior managers commented that most of the individuals were managed on the care programme approach (CPA). This approach ensures mental health care is assessed, planned, and reviewed systematically and it coordinates the range of treatment, care, risk and support needs for people in contact with the service and who have complex care needs. We were told that this integrated model uses Traffic Light Risk Assessment that clearly identifies risks and contingency actions and is supported by a current and clear care plan.

We discussed that the risk assessment and CPA documentation that had not yet been uploaded on to MORSE, the electronic system. This information was held on another platform (Forms Stream). We raised the issue about the impact that this could have on the risk assessment process and were informed that risk management documentation was under review.

Recommendation 1:
Managers should ensure risk assessments are consistent and robust and held on the new electronic system Morse, ensuring that each individual's risk assessments are easily accessible to all.

Recommendation 2:
Managers should conduct an audit of care plan reviews, to ensure they fully reflect the patients' progress towards stated care goals, and that recording of reviews are consistent across all care plans.

Care records

NHS Dumfries and Galloway have adopted the MORSE electronic patient record system for use in Midpark Hospital. The clinical team have been trained in the use of this new system, and the system has been live since January 2024.

Templates had been created to ensure that accurate data was captured during every meeting, aimed at ensuring improvement with cross-team communication. There was also a plan that all documentation would be held on MORSE, ensuring that valuable information sharing, safety and the wellbeing of the individual was held in the one place. We discussed the long-term plan with senior staff for all records to be held on MORSE.

Senior managers informed us that the migration of documentation was currently being reviewed and that they will update the Commission on the progress of those plans in due course.

Multidisciplinary team (MDT)

The ward has a multidisciplinary team (MDT) consisting of a psychiatrist, nursing staff, psychology, dietetics, occupational therapy, pharmacy, and social work. Referrals can be made to all services as and when needed.

There was evidence of regular MDT meetings, with attendance from the full multidisciplinary team depending on the needs of the individual. We were pleased to see that the MDT notes were detailed and included updates from all professionals; the template also ensured that the actions and outcomes were clearly noted.

On the day of the visit, we discussed ongoing concerns in relation to individuals remaining in hospital when they were considered ready for discharge from the service. There were four individuals whose discharge was delayed. This position continues to remain a source of frustration for those individuals, their relatives and the clinical team. Both the MDT meetings and chronological notes had documented that the delays in discharge were actively being addressed by the clinical team with the health and social care partnership.

We heard that access and availability of specialised and suitable community supports was adversely impacting discharge planning. We were told about the lack of availability of support staff locally that meant those who were deemed ready for discharge required to remain in hospital longer than considered necessary. We recognise that this is a national concern.

The service also highlighted how they are addressing the issue. All individuals whose discharge was delayed were under regular review through the MDT meeting. We were also told that on a fortnightly 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 expedite the process.

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, and where a proxy decision maker was appointed, they had been consulted.

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 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. Some patients told us that advocacy input was highly valued.

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. We also discussed with senior managers the role of the community mental health teams in supporting the development of advance statements.

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

The Commission recognises the importance of therapeutic and recreational activities; we were pleased to hear from individuals and staff that this was something that they valued too.

On our last visit to the service, the Commission made a recommendation about the need for occupational therapy input into the service. We were pleased to hear that there was now an occupational therapist employed in the clinical team.

We also heard from both individuals and staff about the positive impact this role was having for individuals in the ward and on their rehabilitation. On discussion with them, and in reviewing the chronological notes, we found evidence of 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.

Some individuals spoke about a range of activities, the assessment and support they had had as they continued their rehabilitation journey, or for some, as they prepared for discharge.

The service had ensured that the individual was engaging in a range of meaningful rehabilitation focussed activities, with each individual 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.

The physical environment

Dalveen ward was a very pleasant and clean ward. On the day, we met 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 a vital and integral part of the ward team.

Individuals are accommodated in single rooms with ensuite facilities and there was access to pleasant, well-kept communal areas.

In addition, there are kitchen facilities which are appreciated and accessed by individuals in the ward and who used these for building on their life skills.

There is also access to an enclosed garden in the unit. This was landscaped with plants and shrubs. On the day of the visit, we saw individuals enjoying this outdoor space. We were told they 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 about how they enjoyed the garden space.

Summary of recommendations

Recommendation 1:
Managers should ensure that risk assessments are consistent and robust, and held on the new electronic system MORSE, ensuring that each individual's risk assessments are easily accessible to all.

Recommendation 2:
Managers should conduct an audit of care plan reviews to ensure they fully reflect the patients' progress towards stated care goals, and that recording of reviews are consistent 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 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.

Contact details.

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk