Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report

Mental Health Services Safe Delivery of Care Inspection

Midpark Hospital

NHS Dumfries & Galloway

27 – 28 July 2026

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About our inspection

Background

The current Healthcare Improvement Scotland Adult Mental Health inspection programme was developed as part of a range of actions to support and improve NHS adult mental health services in Scotland in the context of the COVID-19 pandemic and beyond. Although the initial focus of this work was on Infection Prevention and Control, it was agreed with Scottish Government to broaden the inspection focus from infection prevention and control to a broader assurance function, creating a new and revised 'safe delivery of care' assurance model in NHS adult mental health units.

Our revised methodology will incorporate the HIS Quality Assurance System Quality Assurance Framework and framework and will consider a wide range of standards such as the Health and Social Care Standards (2017) and the new Core Mental Health Quality Standards and indicators (2024).

Further information about the methodology for adult mental health inpatient services safe delivery of care inspections can be found on our website.

Our Focus

Our inspections consider the factors that contribute to the safe delivery of care. In order to achieve this, we:

- observe the delivery of care within the clinical areas in line with current standards and best practice
- attend hospital safety huddles
- engage with staff where possible, being mindful not to impact on the delivery of care
- engage with management to understand current pressures and assess the compliance with the NHS board policies and procedures, best practice statements or national standards, and
- report on the standards achieved during our inspection and ensure the NHS board produces an action plan to address the areas for improvement identified.

About the hospital we inspected

Midpark Hospital is NHS Dumfries & Galloway's mental health facility for inpatient care. It provides a modern, environment for patients requiring specialist intensive mental healthcare. There are six wards including two adult wards, two older adult wards, an intensive psychiatric care unit and a rehabilitation ward.

About this inspection

During the week of 27 July 2026, we carried out two unannounced safe delivery of care inspections within NHS Dumfries & Galloway. As part of this we carried out an

inspection to Midpark Hospital, using our safe delivery of care inspection methodology.

We inspected the following areas:

- Balcary
- Cree
- Dalveen
- Ettrick
- Glencairn, and
- Nithsdale.

We also carried out an unannounced safe delivery of care inspection of maternity inspection to Dumfries & Galloway Royal Infirmary, using our safe delivery of care inspection methodology. Two reports will be published on our inspection findings available on our website.

During our inspection, we:

- inspected the ward and hospital environment
- observed staff practice and interactions with patients, such as during patient mealtimes
- spoke with patients, visitors and ward staff, and
- accessed patients' health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Dumfries & Galloway to provide evidence of its policies and procedures relevant to this inspection. The purpose of this is to limit the time the inspection team is onsite, reduce the burden on ward staff and to inform the virtual discussion session.

On Tuesday 18 August 2026, we held a virtual discussion session with key members of NHS Dumfries & Galloway staff to discuss the evidence provided and the findings of the inspection.

The findings detailed within this report relate to our observations within the areas of the hospital we inspected at the time of this inspection.

We would like to thank NHS Dumfries & Galloway and in particular all staff at Midpark Hospital for their assistance during our inspection.

A summary of our findings

Our summary findings from the inspection, areas of good practice and any recommendations and requirements identified are highlighted as follows. Detailed findings from the inspection are included in the section 'What we found during this inspection'.

We observed staff treating patients with care and compassion and good multidisciplinary teamwork. Patients we spoke with were positive about the care they received.

Daily site safety huddles were used effectively to highlight and mitigate staffing issues.

Quality improvement initiatives relating to falls prevention had resulted in a reduction in falls. In addition, the introduction of discharge packs was supporting more effective discharge planning.

The healthcare environment was in a good state of repair. Several third sector organisations were providing daily activities for patients which patients were very positive about.

Leadership on most of the wards was visible, and succession planning arrangements were in place to support staff development and progression. However, staff reported that access to regular clinical supervision was inconsistent.

Areas for improvement included strengthening governance and oversight to ensure that policies and procedures reflect current guidance, restraint documentation is complete and patient assessments are consistently undertaken and recorded. Feedback from some patients and carers indicated that opportunities for meaningful occupation could be improved.

Further improvements were required to strengthen the identification, assessment and management of risks, including the completion of patient risk assessments and the oversight of ligature and fire safety risks.

What action we expect the NHS board to take after our inspection

This inspection resulted in 11 areas of good practice, three recommendations and 12 requirements.

A requirement in the inspection report means the hospital or service has not met the required standards and the inspection team are concerned about the impact this has on patients using the hospital or service. We expect all requirements to be addressed and the necessary improvements implemented.

A recommendation relates to best practice which Healthcare Improvement Scotland believe the NHS board should follow to improve standards of care.

We expect NHS Dumfries & Galloway to address the requirements. The NHS board must prioritise the requirements to meet national standards. An improvement action

plan has been developed by the NHS board and is available on the Healthcare Improvement Scotland website: www.healthcareimprovementscotland.scot.

Areas of good practice

The unannounced inspection to Midpark Hospital resulted in 11 areas of good practice.

Domain 1	
1	NHS Dumfries & Galloway demonstrated a proactive approach to reducing delayed discharges through the introduction of early discharge planning arrangements and dedicated patient flow support (see page 15).
2	Regular senior charge nurse meetings and dedicated peer support sessions were in place which facilitated shared learning, problem solving and professional support (see page 15).
3	Quality improvement work undertaken in relation to falls has helped to reduce number of incidents (see page 15).
4	Discharge packs and ongoing work surrounding these is supporting effective discharge and increasing communication with community teams (see page 15).

Domain 2	
5	Midpark Hospital demonstrated a commitment to workforce development through structured succession planning and enhanced learning opportunities for nursing and healthcare support staff (see page 19).

Domain 4.1	
6	Centralised cafe allowed a space for relatives to meet and was a welcoming environment (see page 25).
7	Within the older adult wards, movement sensors were used to alert staff when patients mobilised independently, supporting falls prevention while avoiding more restrictive interventions such as continuous observation (see page 25).

Domain 4.3	
8	Psychology input to support staff through debriefs and one to one work when needed (see page 30).
9	We observed staff demonstrating personalised, kind and caring interactions with patients (see page 30).
10	Students provided positive feedback about their placement experience (see page 30).
11	A comprehensive and accessible range of wellbeing services and peer support networks are available to support staff health, wellbeing and inclusion (see page 30).

Recommendations

The unannounced inspection to Midpark Hospital resulted in three recommendations.

Domain 1	
1	NHS Dumfries & Galloway should continue to progress seeking medical cover to reinstate access to the dedicated alcohol detoxification service (see page 16).

Domain 4.3	
2	NHS Dumfries & Galloway should support staff through regular clinical supervision (see page 30).

Domain 6	
3	NHS Dumfries & Galloway should consider improvement of the outdoor area for patients within Midpark Hospital to develop a more accessible therapeutic space (see page 32).

Requirements

The unannounced inspection to Midpark Hospital resulted in 12 requirements.

Domain 1	
1	NHS Dumfries & Galloway must ensure effective and appropriate governance approval and oversight of polices are in place to ensure the most up to date guidance is in use (see page 16). This will support compliance with: Quality Assurance Framework Criterion 4.1.
2	NHS Dumfries & Galloway must ensure that all incidents reported on the electronic system are sufficiently recorded and that there is a robust system in place for: • review • closure • learning from incidents and, • effective communication and feedback from incident reports (see page 16). This will support compliance with: Core Mental Health Standards (2023) Criterion 5.8, Quality Assurance Framework criteria 2.3, 2.5 and 2.6, Health and Social Care Standards (2017) Criterion 4.19 and A national framework for reviewing and learning from adverse events in NHS Scotland.

Domain 2	
3	NHS Dumfries & Galloway must ensure all staff complete mandatory, role-specific training required to safely carry out their role, supported by protected learning time to maintain safe staffing levels and staff development (see page 19). This will support compliance with: Health Care (Staffing) (Scotland) Act 2019 Criterion 12II, Core Mental Health Standards (2023) criteria 4 and 4.1.
4	NHS Dumfries & Galloway must ensure that all patient documentation including but not limited to NEWS2 and continence assessments are undertaken at point of admission and are reviewed and updated as appropriate, with care plans implemented and kept up to date to meet patient needs. All paperwork should be appropriately signed by registered nurses (see page 19). This will support compliance with: Quality Assurance Framework Criterion 4.1, Nursing and Midwifery Standards for student supervision and assessment (2003) and relevant codes of practice of regulated healthcare professions.

Domain 4.1	
5	NHS Dumfries & Galloway must ensure implement and maintain effective systems to ensure that current Mental Health (Care and Treatment) (Scotland) Act 2003 documentation is easily accessible to all relevant staff (see page 25). This will support compliance with: Mental Health (Care and Treatment) (Scotland) Act 2003.
6	NHS Dumfries & Galloway must ensure effective completion of ligature risk assessments and any identified risks to ensure these are effectively mitigated and underpinned by an agreed organisational ligature policy (see page 25). This will support compliance with: Health and Social Care Standards (2017) criteria 5.19 and 4.19 and Quality Assurance Framework (2022) indicators 2.6.and 4.1.
7	NHS Dumfries & Galloway must ensure all areas within wards are risk assessed to identify and mitigate any risks associated with restricted lines of sight (see page 26). This will support compliance with: Health Building note 03-01 Adult acute mental health units (2014)
8	NHS Dumfries & Galloway must ensure robust fire safety management arrangements are in place, with identified fire risks supported by documented risk assessments, mitigation measures and available action plans. Staff should understand their role the management of fire safety risks (see page 26).

	This will support compliance with: Fire Safety (Scotland) Regulations (2006), The Fire (Scotland) Act (2005) Part 3 and NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017).
9	NHS Dumfries & Galloway must ensure when patients require seclusion it is implemented and documented consistently across the service and underpinned by an agreed organisational seclusion policy (see page 26). This will support compliance with: Mental Welfare Commission Rights, Risks and Limits to Freedom (2025) and Health and Social Care Standards (2017) Criterion 4.1.

Domain 4.3	
10	NHS Dumfries & Galloway must ensure effective systems are in place to support staff when working in an unfamiliar area (see page 30). This will support compliance with: Health and Social Care Standards (2017) criteria 1.3, 1.20, 1.24, 3.14, 4.11, 4.14 and 5.19 and Quality Assurance Framework criteria 2.2, 4.1 and 6.1.

Domain 6	
11	NHS Dumfries & Galloway must ensure work towards the elimination of mixed sex accommodation, and that effective systems and process are in place to: • uphold the highest standards of care, and • ensure adult support and protection issues are always effectively assessed (see page 32). This will help support compliance with: Health and Social Care Standards (2017) criteria 4,1, 4,1 and 5.19 and Quality Assurance Framework (2022) criteria 6.1 and 6.2.
12	NHS Dumfries & Galloway must ensure adequate staffing to enable meaningful activity to be provided to enhance recovery and promote wellbeing (see page 32). This will help support compliance with: Health Care (Staffing) (Scotland) Act (2019), Health and Social Care Standards (2017) criteria 1.19 and 1.25 and Core Mental Health Standards Criterion 4.6.

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

We observed good work in relation to patient flow, effective multidisciplinary working, with evidence of improvement activity to reduce delayed discharges and falls. We identified areas for improvement in policy review arrangements, incident documentation and the communication of learning from incidents.

Midpark Hospital is NHS Dumfries & Galloway's mental health facility for inpatient care. It opened in 2012 and replaced the accommodation previously provided by Crichton Royal Hospital. It provides a modern environment for patients requiring specialist intensive mental health care. There are six wards including two adult wards, two older adult wards, an Intensive Psychiatric Care Unit and a rehabilitation ward.

Admissions to Midpark Hospital are based on clinical need and at the time of our onsite inspection the hospital was not operating at full capacity with a number of available beds.

When additional capacity is required, a 'pass bed' is utilised. A pass bed remains allocated to a patient who is on planned leave from the ward, such as home leave, allowing the bed to be temporarily used by another patient requiring admission.

At the time of inspection one ward was utilising a pass bed for another patient to accommodate a patient who required admission to a specific ward. Staff advised this was discussed at the morning huddle and that professional judgement had been applied to assess and mitigate any associated risks. Inspectors attended the huddle and observed appropriate contingency arrangements were in place to accommodate the patient who was on pass elsewhere within the hospital should they return from leave earlier than planned.

We were provided with NHS Dumfries & Galloway Midpark Hospital Bed Management and Occupancy Escalation Plan. This plan outlines staff responsibilities and escalation processes for identifying, managing and mitigating risks to patient safety associated with high bed occupancy. It includes a RAG rated (red, amber, green) escalation framework with clearly defined trigger points and actions linked to occupancy levels, as well as additional bed capacity huddles to support decision making during periods of increased pressure. Triggers are used alongside professional judgement to determine the appropriate level of escalation. Staff we spoke with demonstrated a good understanding of the escalation arrangements in place.

We reviewed the NHS Dumfries & Galloway Mental Health Services Directorate, Admission, Discharge and transfer policy. This was dated 2017 with a review due in April 2019. Senior managers acknowledged that the policy was overdue for review and advised that a review process had commenced prior to the inspection. The revised policy is expected to be in place by December 2026. We acknowledge that work is

underway. However, a requirement has been given to support continued improvement in this area.

At the time of inspection there were 13 delayed discharges. A delayed discharge occurs when a patient who is clinically ready to leave hospital cannot do so due to a lack of care support or suitable accommodation such as a care home placement. Delayed discharge can have a significant impact on a person's health and wellbeing, including the loss of independence, autonomy and confidence.

NHS Dumfries & Galloway worked with Healthcare Improvement Scotland to participate in a delayed discharge improvement programme. We were provided with evidence of the project implementation which showed improved patient flow and discharge processes. Since March 2026, meeting structures have been redeveloped to support improved multidisciplinary communication, escalation processes and earlier discharge planning from the point of admission. Information provided suggests this had contributed to a 35% reduction in delayed discharges. A patient flow coordinator visits the wards weekly to support staff in identifying and overcoming barriers to discharge, including issues relating to social work involvement and wider discharge planning arrangements.

In addition, one ward worked with the Scottish Patient Safety Programme for Mental Health safety at point of transition collaborative to develop and implement a safe discharge pack aimed at improving safety and communication during the transition from hospital to community. The packs include details of follow up appointments with community mental health team, discharge medication and out of hours support contact numbers. They were developed collaboratively with nursing staff, patients, families and carers. Review activity identified opportunities to strengthen discharge planning, follow up arrangements and communication between inpatient and community teams. Although the initiative demonstrated positive outcomes, inspectors were not informed of any current plans to introduce the discharge pack across other wards.

Public Health Scotland reported in July 2025 that 31.4% of Child and Adolescent Mental Health Services (CAMHS) inpatient admissions across NHS Scotland occurred out with specialist CAMHS units. The Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice states that a child or young person should only be admitted to an adult ward in exceptional circumstances, such as when no specialist CAMHS bed is available.

Staff advised that where an inpatient CAMHS bed is not immediately available children and young people may be admitted temporarily to adult mental health wards. The NHS Dumfries & Galloway admission, discharge and transfer policy includes an exceptional pathway to support clinical decision making and risk management in these circumstances for both in and out of hours. Where admissions are deemed suitable this is risk assessed and daily input from CAMHS is provided and the young person is nursed on continuous intervention throughout their admission. Staff reported that

such admissions are very infrequent. Where such admissions do take place, staff described clear reporting processes that align with Scottish Government guidance for Admission to Adult Mental Health Wards for under 18's. Review of incident data found no evidence of any admissions of children or young people to adult mental health wards during the three months prior to inspection.

We were told about the nurse hospital lead role. The role is undertaken by senior nursing staff and is supported by an on-call senior charge nurse. Staff described this as an accessible and supportive point of contact for nursing staff across the hospital. The role provides senior nursing oversight and facilitates timely advice and guidance on clinical, patient safety and staffing matters.

We reviewed the Midpark nurse hospital lead guidelines, which clearly set out the role, responsibilities and escalation pathways. Staff demonstrated a good understanding of processes for escalating concerns relating to staffing, patient safety and clinical risk and felt confident that concerns would be responded to appropriately.

We observed effective multidisciplinary team working, with ward staff reporting positive communication and collaboration with occupational therapy, physiotherapy and dietetic services. Staff were able to access and refer to these services as required.

Inspectors attended the daily morning site huddle. This was attended by nursing team leaders, senior managers and community mental health team representatives. Discussions included patient acuity, enhanced observations, admissions, discharges, incidents and staffing levels. We observed an open and supportive forum where staff pressures and clinical concerns were discussed, with appropriate actions agreed including redeployment of staff to maintain safe staffing levels. Review of huddle documentation accurately reflected discussions and actions taken.

Ward staff told us that there are weekly consultant handovers and ward-based shift handovers where admissions, current risks and key patient concerns are routinely discussed to support effective communication. We observed a ward handover during our onsite inspection, where relevant information regarding admissions, risks and patient care was communicated effectively.

We were told senior charge nurses meet weekly to discuss any operational issues, service developments and ward activity. A separate weekly peer support forum for senior charge nurses is also in place. Staff spoke positively about these arrangements, describing them as supportive and beneficial for leadership development. Feedback included the value of the forum in supporting transition from band 6 charge nurse role into a senior leadership position.

The hospital has one dedicated specialist bed for alcohol detoxification. However, this bed had been unavailable for use for several months due to the lack of specialist medical cover to support the service.

The lack of specialist medical support has been recorded on the risk register since January 2026. A risk register is a tool used by NHS boards to identify, assess and manage risks. To reduce this risk, patients identified as low risk continue to receive community based detoxification. Senior managers confirmed that elective admissions for detoxifications were not being undertaken within Midpark Hospital. Patients assessed as requiring higher levels of clinical support are admitted to Dumfries & Galloway Royal Infirmary for detoxification, with input from the Specialist Drug and Alcohol Service (SDAS).

Information provided demonstrated there was a waiting list for patients who required alcohol detoxification. We were told the service reviewed the waiting list and identified that some patients had experienced waits of up to 12 months. We were advised that these delays, in some cases, had resulted in continued harmful alcohol use and deterioration in individuals physical and psychological wellbeing. While alternative arrangements were in place for patients assessed as requiring higher levels of clinical support, this measure did not fully replace access to the dedicated inpatient detoxification service. Reinstating the service would support timely access to specialist treatment, reduce prolonged waits and help ensure that patients receive care in the most appropriate environment for their needs. Although mitigating arrangements had reduced immediate risks for higher risk patients, the prolonged unavailability of the service continued to limit patient access to this specialist intervention. The NHS board advised that efforts to reestablish the dedicated alcohol detoxification service are ongoing. During periods of service redesign or temporary unavailability, NHS boards should consider undertaking a high level impact assessment including seeking feedback from patients and carers where appropriate. This would support understanding of the effect on patient experience, pathways of care and outcomes, and help inform future service provision. A recommendation has been given to support improvement in this area.

The Healthcare Improvement Scotland national framework for reviewing and learning from adverse events states that all adverse events should be reviewed, with the level of review determined by the severity of harm and significance of the event. Senior managers advised that NHS Dumfries & Galloways Adverse Events Policy and standard operating procedure were under development; in the interim, staff were following Healthcare Improvement Scotland's Adverse Events Framework. The draft policy describes processes for reporting, reviewing and learning from adverse events, together with governance arrangements intended to support implementation. Senior managers advised the policy is due to approval in October 2026. Midpark Hospital supports organisational learning from incidents through a team based quality review process, in which a multidisciplinary team evaluates the quality, safety and effectiveness of care and services.

We reviewed incident reports submitted by staff through NHS Dumfries & Galloway electronic incident reporting system during the three months prior to this inspection. Staff told inspectors that they were encouraged to report incidents, near misses or

patient safety concerns. We were advised that incident reports are reviewed by senior staff and signed off, usually within a week, supporting timely identification of risks and opportunities for learning. However, staff reported that they did not consistently receive feedback following submission of an incident report. Whilst inspectors were assured that incidents were being reported and reviewed, inconsistent feedback to staff could reduce assurance that learning from incidents was being effectively shared and embedded across the service. This has the potential to reduce staff engagement with reporting processes and may limit opportunities for organisational learning and quality improvement. A requirement has been given to support improvement in this area.

Within incident reports reviewed, the three most frequently reported incident categories within Midpark Hospital were violence and aggression (33%), slips, trips and falls (18%), and restraint (15%). NHS Dumfries & Galloway's Conflict Management Procedure sets out approaches to prevent and manage violence and aggression, including the use of environmental measures, effective communication and the requirement for any physical intervention to be reasonable, proportionate and followed by a post incident review and debrief.

Inspectors found that incident reports submitted in relation to physical restraint were often brief and did not consistently record key information, such as the type and duration of restraint used, the number of staff involved, physical health monitoring undertaken or the deescalation strategies attempted prior to restraint. As a result, records did not provide sufficient assurance that interventions were necessary, proportionate, and in line with principles of least restrictive practice, as outlined within Mental Welfare Commission restraint guidance.

NHS Dumfries & Galloway Conflict Management Procedure states staff are accountable for their decisions and must be prepared to provide a rationale for their actions. However, it does not specify the information that should be recorded within an incident report to support this. We discussed this with senior managers who explained a recent change to a new electronic incident reporting system had resulted in the removal of specific data fields which captured restraint related information leading to the identified information gaps. We raised this with senior managers who advised this information is captured within patient care records and confirmed this has been highlighted with the adverse event team to strengthen the new electronic reporting system by introducing additional data fields to improve the quality of reporting and assurance. A requirement has been given to support improvement in this area.

We were provided with the NHS Dumfries & Galloway Mental Health Governance and Development Meeting minutes from June 2026 which demonstrated that governance risks, adverse events, and service improvement activity were subject to regular oversight. Inspectors found that issues recorded within the minutes were consistent with findings identified during the inspection, including workforce challenges,

medication safety concerns and environmental risks, providing assurance that these matters had been recognised and were being monitored through established governance processes.

A regular programme of audits can support the early identification of risks, compliance with policy, and patient and staff safety. We were provided with infection prevention and control and care plan audits for all wards. Completed action plans were detailed, included appropriate timescales and set out how learning and actions would be communicated to staff.

Excellence In care (EiC) provides a national framework to support assurance, risk identification, and continuous improvement across NHS Scotland services. Inspectors reviewed Midpark Hospital's EiC care assurance reports for May to July 2026, which demonstrated ongoing monitoring of key quality indicators, including falls.

Patients falls were identified as a significant area of focus. While the rate of falls increased in April 2026, improvement was evident by June 26. This was consistent with incident data and entries on the risk register, where falls had been identified as an ongoing risk.

Inspectors saw evidence of actions to mitigate the risk, including falls risk assessments on admission, development of a falls improvement project and regular review of falls data through the falls innovation group. Meeting minutes demonstrated multidisciplinary learning and discussion of contributory factors and preventive measures, providing assurance that the service was actively monitoring and seeking to reduce falls across the hospital.

Local Care Assurance within the Excellence in Care report showed positive feedback from patients and carers. Culture care assurance found that staff feel valued. However, staff advised that clinical workload pressures alongside competing priorities and staffing resource availability continue to present challenges within the services. This is discussed further in 4.3.

Areas of good practice

Domain 1	
1	NHS Dumfries & Galloway demonstrated a proactive approach to reducing delayed discharges through the introduction of early discharge planning arrangements and dedicated patient flow support.
2	Regular senior charge nurse meetings and dedicated peer support sessions were in place which facilitated shared learning, problem solving and professional support.
3	Quality improvement work undertaken in relation to falls has helped to reduce number of incidents.
4	Discharge packs and ongoing work surrounding these is supporting effective discharge and increasing communication with community teams.

Recommendation

Domain 1	
1	NHS Dumfries & Galloway should continue to progress seeking medical cover to reinstate access to the dedicated alcohol detoxification service.

Requirements

Domain 1	
1	NHS Dumfries & Galloway must ensure effective and appropriate governance approval and oversight of polices are in place to ensure the most up to date guidance is in use.
2	NHS Dumfries & Galloway must ensure that all incidents reported on the electronic system are sufficiently recorded and that there is a robust system in place for: • review • closure • learning from incidents, and • effective communication and feedback from incident reports.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

The majority of staff told us they are well supported, with examples of workforce development, leadership support and innovative practice. Mandatory training compliance was generally satisfactory, and patient care documentation was mostly completed to a good standard. However, inspectors identified some gaps in assessments for physical health monitoring and nutritional care.

Staff we spoke with told us they felt well supported and able to seek advice and support from senior leaders. Senior charge nurses were visible and accessible across most wards.

Staff told inspectors of succession planning arrangements in place to support progression and development of band 5 staff nurses. Staff participating in these programmes are encouraged and supported to undertake responsibilities associated with more senior roles, helping to develop leadership skills and support career progression. Evidence reviewed included individual development plans that identified learning objectives and opportunities for growth. Staff spoke positively about these arrangements. However, in one ward staff reported that staffing pressures and frequent redeployment limited the time available for this development opportunity, highlighting variation in staff experience across the service.

Further evidence of commitment to workforce development was demonstrated through the provision of development opportunities for healthcare support workers. This included completion of competency frameworks to enable them to support registered staff when caring for patients undergoing Electro Convulsive Therapy (ECT).

We asked for compliance rates for all the mandatory national and board specific staff training programmes for Midpark Hospital. Adult and child support and protection training provide staff with the information required to promote the protection and wellbeing of adults and children. It also highlights the process to follow if staff are concerned that a person has been or is at risk of being harmed. Training compliance rates for adult and child support and protection ranged from 88% and 100%.

Other training compliance variation includes Malnutrition Universal Screening Tool (MUST) from 92% to 100% and basic life support training from 76% to 100%. Basic life support training is essential to ensure staff have the skills and knowledge required to respond effectively in an emergency.

Physical restraint should only be used as a last resort to prevent a person from harming themselves or others, or to provide necessary help or treatment. The Mental Welfare Commission highlights that physical restraint should only be implemented by staff who have been fully trained in the methods of restraint. Physical restraint training supports staff in how to apply techniques safely without causing unnecessary harm or distress. Training in the prevention and management of violence and aggression is essential to ensure staff can safely deescalate and manage incidents.

Compliance with high level training which includes face to face physical restraint training is mandatory for all ward based staff and ranged from 70% to 93%. Compliance with medium level training which incorporates elements of theory and breakaway techniques, was 100% across all wards and is attended by medical staff, support services, portering staff and mental health pharmacists. We did not see any incidents reported in evidence provided relating to reduced availability of staff suitably trained in the prevention and management of violence and aggression.

While mandatory training compliance was generally satisfactory, a requirement has been made to support further improvement and provide assurance that all staff complete required training within the expected timescales.

In one ward area, staff told us that they regularly provided end of life care as part of their role and responsibilities. This included the preparation and use of syringe drivers which deliver a continuous infusion of medication to help manage symptoms and maintain comfort for patients approaching the end of life. Staff we spoke with explained that community palliative care nurses had contributed to the syringe driver training programme and had spent time with ward staff discussing end of life care and symptom management. Staff we were able to speak with also told us they felt confident and competent in providing end of life care.

Evidence provided, showed that most nurses on the ward had completed training in the use of syringe drivers. A staff member from another ward had also completed the training, providing additional support when required.

We observed that patient care documentation was generally completed to a good standard. Inspectors found that risk assessments relating to mental health, nutrition,

falls and pressure ulcer prevention were routinely completed and reviewed. Mental health risk assessments provided a structured assessment to enable clinicians to assess and manage risks. Records demonstrated that risk assessments were up to date and evidenced patient involvement in their care.

NEWS2 (National Early Warning Score 2) is a standardised clinical tool used across the NHS to identify adult patients who are at risk of deterioration due to acute illness. It helps staff recognise early signs of deterioration and escalate care appropriately. The Midpark Hospital Admission, discharge and transfer policy and the NHS Dumfries & Galloway Recognition and Management of the Deteriorating Patient state that patients should receive a physical health assessment on admission. Inspectors found that NEWS2 documentation was generally completed to a good standard. Ward staff were knowledgeable about medical emergency procedure and escalation from NEWS2 scoring to the on call doctor. Due to being a standalone service staff will call 999 in the event of emergency.

Inspectors identified examples where assessment and care planning processes had not been fully completed. Some care plans lacked sufficient individualisation to fully reflect patients' assessed needs. This included a patient who did not have a completed Malnutrition Universal Screening Tool (MUST) assessment and a patient with identified continence needs who did not have a documented continence assessment or care plan. As a result, inspectors were not assured that all physical health and personal care needs were being consistently assessed, care planned and monitored.

Review of incident records identified an example where a deteriorating patient had not undergone NEWS2 monitoring for four days following admission, limiting opportunities to identify and escalate deterioration at an earlier stage. Senior managers advised following this incident, learning had been shared with nursing and medical staff around the importance of timely and ongoing physical observations.

Inspectors also observed that student nurse documentation within electronic patient records was not consistently countersigned in line with professional and organisational requirements. In one instance, a MUST assessment completed by a student nurse had been signed off by a healthcare support worker. A requirement has been given to support improvement in this area.

Staff on one ward told us they were piloting a digital pain check system, which uses a handheld electronic device to assess pain by analysing facial expressions and other pain indicators. The technology had been introduced to support the assessment of pain in patients with cognitive impairment, who may have difficulty recognising, communicating or expressing pain. Staff advised that they found the tool particularly useful when assessing patients whose communication needs presented barriers to traditional pain assessment methods. Inspectors saw in evidence that this tool was being used consistently to monitor patients and help reduce stress and distress in relation to unrecognised pain. Senior managers advised that appropriate information governance considerations had been undertaken and that the project had been

reviewed through relevant organisational governance structures prior to implementation.

Area of good practice

Domain 2	
5	Midpark Hospital demonstrated a commitment to workforce development through structured succession planning and enhanced learning opportunities for nursing and healthcare support staff.

Requirements

Domain 2	
3	NHS Dumfries & Galloway must ensure all staff complete mandatory, role-specific training required to safely carry out their role, supported by protected learning time to maintain safe staffing levels and staff development.
4	NHS Dumfries & Galloway must ensure that all patient documentation including but not limited to NEWS2 and continence assessments are undertaken at point of admission and are reviewed and updated as appropriate, with care plans implemented and kept up to date to meet patient needs. All paperwork should be appropriately signed by registered nurses.

Domain 4.1 – Pathways, procedures and policies

Quality indicator 4.1 – Pathways, procedures and policies

We observed positive examples of care, including effective personal alarm systems, least restrictive approaches to observation, dementia friendly environments, and welcoming communal spaces. However, areas for improvement included access to Mental Health Act documentation, ligature risk management, governance of restrictive practices and the management of fire and smoking risks.

The use of personal safety alarms is an important control measure within inpatient mental health settings, enabling staff to quickly summon assistance in an emergency and supporting a safe environment for patients and staff. A ward safety alarm is a system designed to alert other members of staff to an emergency, facilitating a rapid and coordinated response. Staff told us they had access to personal safety alarms, which were integrated into the ward's alarm system to facilitate a prompt response to emergency situations. Across all wards, there were sufficient personal alarms available for staff use, with arrangements in place for signing in and out. During handover, a designated member of staff was identified to respond to alarm activations.

During our onsite inspection, several patients were requiring continuous intervention due to their mental health needs. Continuous intervention is used to support patient safety and individual care needs. It provides increased levels of support and engagement to reduce the risk of harm to the patient or others.

NHS Dumfries & Galloway's Continuum Intervention Policy reflects the principles in Healthcare Improvement Scotland's Continuum-based Intervention Policy using the From Observation to Intervention model, which promotes a therapeutic, dynamic, and least restrictive approach to risk management. The model emphasises the importance of a clinical pause when risk escalates, ensuring decisions regarding continuous intervention are informed by a contemporaneous assessment of risk and need, rather than being implemented as a default response. This approach recognises that acute distress may often be effectively managed through timely therapeutic interventions, thereby reducing the requirement for continuous intervention and supporting recovery focused care.

Senior charge nurses described ongoing engagement with the Scottish Patient Safety Programme. The Scottish Patient Safety Programme (SPSP) is a national quality improvement initiative that supports NHS boards to improve the safety and reliability of care, reduce avoidable harm, and promote a culture of continuous improvement through evidence-based safety and quality improvement approaches.

NHS Dumfries & Galloway's Continuous Intervention policy is aligned with national guidance and reflects the principles of least restrictive practice. Patients on continuous intervention at time of inspection were observed to be cared for in accordance with local policy.

Within the older adult wards some bedrooms were fitted with bed movement sensors as part of a falls prevention initiative. The bed sensors are used when there is an identified risk of falls. These sensors detect movement when a patient attempts to get out of bed unassisted and generate an alert to staff when activity is identified which enables staff to respond promptly and potentially reduce the risk of falls. This was seen as a least restrictive measure instead of the patient being placed on continuous interventions.

The Mental Health (Care and Treatment) (Scotland) Act 2003 states a person may be detained in hospital when they are experiencing a mental illness and require assessment or treatment that cannot be safely or effectively provided on a voluntary basis.

Under the Mental Health (Care and Treatment) (Scotland) Act 2003, healthcare staff must be able to access current and accurate detention documentation to demonstrate the legal authority for a patient's detention, care, and treatment. We found that the majority of staff were able to access Mental Health (Care and Treatment) (Scotland) Act 2003, documentation and associated legal paperwork through the electronic care record system. However, on one ward staff were unable to readily locate current detention certificate documentation, when requested. While the required paperwork was subsequently obtained from medical records, inspectors observed difficulties accessing the most current detention orders. Paper files contained multiple historical documents, some of which were superseded and out of date, creating the potential for confusion regarding an individual's current legal status and authority for detention.

We reviewed two incident reports relating to Mental Health (Care and Treatment) (Scotland) Act 2003 documentation, where detention paperwork was either unavailable when required or detention authority had lapsed, resulting in emergency detention paperwork being completed.

The inability to promptly access accurate and up to date detention documentation presents a risk that staff may be unable to demonstrate the legal authority for detention and treatment. This may lead to delays in decision making, potential breaches of patient rights and reduced organisational assurance regarding compliance with Mental Health (Care and Treatment) (Scotland) Act 2003 requirements. We discussed these concerns with senior managers who advised that all documentation should be accessible electronically and that staff should be aware of how to access it. A requirement has been made to support improvement in this area.

We reviewed a range of evidence relating to the assessment and management of environmental ligature risks, including environmental walk round documentation, health and safety inspection reports, the risk register and the ligature risk assessment. While NHS Dumfries & Galloway do not have a specific ligature risk policy, there was evidence that risks are considered through existing governance arrangements. However, the ligature risk assessment provided did not capture all ligature risks observed during the inspection, including damaged anti-ligature fittings and protruding screws. This is not consistent with the Health and Safety Executive's guidance on managing ligature risks which require organisations to systematically identify, assess and monitor ligature and anchor points through regular environmental audits. In addition, the Royal College of Psychiatrists' Quality Network for Inpatient Mental Health Services standards state that ligature risk assessments should be reviewed at least annually and that identified risks should be subject to clear mitigation measures. Senior managers confirmed that the potential ligature risks identified during the inspection had been removed.

We also reviewed health and safety reports for all wards. These were single page reports with a list of areas inspected and highlighted areas that required attention. However, the specific risks were not clearly recorded and there was no accompanying action plan to demonstrate how these would be addressed, monitored or reviewed. A requirement has been given to support improvement in this area.

During our onsite inspection we identified an area within one ward where staff's ability to maintain clear lines of sight of patients was restricted. This may limit the timely identification of incidents, changes in presentation, deterioration in physical or mental health, and other risk related behaviours. Inspectors raised these concerns with ward staff and senior managers. Staff advised that patients assessed as presenting an increased risk would be subject to enhanced observation and supervision when using the area. However, the potential risks associated with patient use of the area, including the reduced lines of sight, had not been identified within the ward's environmental risk assessments. A formal risk assessment of the environment

would support effective governance and oversight by ensuring that any associated risks are identified, mitigated and subject to ongoing review. A requirement has therefore been given to support improvement in this area.

All wards inspected were clean, tidy and well maintained. The ward environments appeared modern and provided a comfortable setting for patients. On one ward inspectors observed several dementia friendly features designed to support orientation and reduce distress for patients living with dementia. This included the ward exit being designed to resemble a bookcase rather than a conventional door. This approach is considered dementia friendly because it helps to minimize exit seeking behaviours and reduce anxiety associated with locked ward exits. The environment reflected recognised dementia friendly design principles and promoted a calm and supportive setting for patients.

During the mealtimes we observed patients were supported appropriately, with communal eating encouraged and staff facilitating meal choices and refreshments for those eating in their rooms. However, incident data identified three occasions within the previous three months where patients in one ward did not receive meals that met their assessed dietary requirements. These incidents included the provision of incorrect meals, inappropriate texture modified diets and failure to supply suitable meals despite the correct order having been placed. Senior managers advised that the incidents had been reported to and discussed with the catering department, and that the dietetic service had undertaken a review to identify any additional mitigating actions required to reduce the risk of recurrence.

In one ward area a section of handrail was damaged, leaving exposed nails and presenting a potential safety hazard. We raised this during the inspection and senior managers confirmed that the defect had been reported and immediate action had been taken to make the area safe while a replacement handrail is being procured. The existing handrail was secured and made safe for continued use as a temporary measure to minimise the risk of falls until the new handrail is installed.

Since September 2022, the Prohibition of Smoking Outside Hospital Buildings (Scotland) Regulations have made it unlawful to smoke within 15 metres of any NHS hospital building in Scotland, including mental health hospitals. Consequently, all NHS boards are required to comply with this legislation and should have robust local policies and procedures in place to support implementation and monitoring.

NHS Dumfries & Galloway provided its smokefree policy. While the policy outlines the organisation’s commitment to compliance with smokefree legislation, it does not clearly describe how risks associated with patients retaining smoking paraphernalia, such as lighters, are mitigated. The NHS board also provided its policy on the recording and management of patients’ belongings, which identifies matches and lighters as prohibited items and places responsibility on staff to ensure compliance through appropriate searches in line with NHS Dumfries & Galloway search guidelines, including following periods of leave from the ward.

NHS Dumfries & Galloway's risk register reflects identified risks associated with compliance with current smoking legislation and patient smoking behaviours. Mitigating actions included communication with Public Health Scotland and the Scottish fire and rescue service, the provision of 'Quit your way' support and smoking cessation links in each ward, and a requirement for all staff to read the NHS Dumfries & Galloway Smokefree Policy. While the risk register identified assessment for Nicotine Replacement Therapy (NRT) on admission as a mitigating action it did not reference the management of smoking paraphernalia or address the risks associated with patients retaining items capable of initiating fire.

Despite these measures, review of the evidence identified 21 recorded incidents (within a three month period prior to inspection) of smoking policy breaches involving patients smoking within their rooms which may pose a fire risk. The frequency of these incidents suggests that existing controls may not be operating effectively and raises concerns of the effectiveness of associated assurance mechanisms to manage fire safety risks and ensure consistent implementation of established procedure. A requirement has been given to support improvement in this area.

On one ward, inspectors observed that a plant room adjoining the kitchen was being used to store ward supplies and staff personal belongings. We also found that the fire door to the room had been wedged open, which could compromise fire containment measures designed to protect patients, staff and the ward environment. This issue was escalated during the inspection and was rectified by staff while inspectors were on site.

We asked staff about their awareness of and responsibilities in relation to fire risk assessments. Although staff reported awareness of the assessment process, several staff perceived responsibilities for fire risk management to rest primarily with senior charge nurses. Effective fire safety management depends on a shared responsibility model, whereby all staff contribute to the ongoing identification, reporting, and mitigation of risks. Without this collective approach, there is an increased likelihood that hazards may not be recognised or addressed in a timely manner, potentially compromising the safety of patients, staff, and visitors. During the inspection there was a fire alarm activation which we observed staff responded to promptly. Mandatory training compliance levels for fire safety awareness was between 87% and 100%.

NHS boards are required to comply with fire safety standards set out within NHS Scotland Firecode (2007). Review of ward level health and safety reports identified a range of environmental fire risks. However, accompanying risk assessments, mitigation measures, and action plans were not consistently evidenced. We were provided with Scottish Health Technical Memorandum 86 Fire risk assessments for all wards and the main hospital site. However, these were completed in November 2024 with a renewal date of November 2025. These risk assessments identify several fire doors were wedged open and that the use of lighters are monitored by staff. Due to staff absence

within the estates department the fire risk assessments for 2025 were inaccessible. Senior managers advised that there are no outstanding actions that senior managers have been made aware of. The lack of access to current fire risk assessments may limit the NHS board's ability to demonstrate that identified risks are being effectively managed and that fire safety requirements are being met. The Fire Safety (Scotland) Regulations which impose a duty to review fire risk assessments where there is reason to suspect it is no longer valid or where there have been significant changes to the building layout or work practices. A requirement has been given to support improvement in this area.

Seclusion is a restrictive practice whereby an individual is isolated and prevented from leaving a room or area to manage behaviour that presents a significant risk of harm to themselves or others. While reviewing incident reports, inspectors identified examples of patients being restricted to side rooms. These incidents raised questions as to whether interventions meeting the definition of seclusion, or functionally similar restrictive practices, were being consistently recognised, recorded and subject to appropriate governance. The use of seclusion requires clear governance arrangements, defined decision making processes and oversight to ensure that any restriction is lawful, necessary, proportionate and regularly reviewed.

Senior nursing staff advised that seclusion is not used within the service and confirmed that there is no seclusion policy in place. However, discussions with senior managers identified differing interpretations of what may constitute seclusion or a seclusion-like restrictive practice, which may impact on the consistent identification and governance of such interventions. The Mental Welfare Commission's Use of Seclusion good practice guidance states that where a patient is restricted and prevented from leaving their room, this should be recorded as seclusion regardless of the reason for the restriction.

The absence of a seclusion policy and a shared understanding of what constitutes seclusion may result in restrictive interventions not being managed in line with current best practice guidance. A requirement has been given to support improvement in this area.

Standard infection control precautions should be consistently applied by all staff to reduce the risk of cross infection. These include hand hygiene, patient placement, use of personal protective equipment (PPE), and the safe management of waste, linen and sharps. Inspectors observed that PPE including gloves and aprons were readily available and appropriately stored. Clinical waste and linen appeared to be managed and stored in line with national guidance across all ward areas.

The limited availability of hand soap within patient areas had been identified as a risk on the organisational risk register due to the removal of hand soap to promote wider patient safety. Mitigations included hand soap should only be removed from patients assessed as being at an increased risk of adverse events, with alternative hand hygiene

products provided until safe to reintroduce hand soap. This was consistent with our observations onsite and staff told us patients could be provided with soap if required.

The communal spaces of the hospital were clean, well maintained and provided a welcoming environment for patients, visitors and staff. The central cafe known as the hub, was well used by patients, visitors and staff. We observed that staff working within the cafe knew patients well and provided a warm and welcoming atmosphere. It was evident that patients valued the opportunity to access this social space, which supported social interaction and engagement.

During the inspection, two patient bedrooms were out of use due to an ant and wasp infestation. The issues had been reported to the estates department, and an external contractor had been scheduled to attend during a day of inspection. We asked about process in place if additional bed capacity was required while the two bedrooms were out of use. We were advised that risks would be mitigated by utilising alternative vacant bed spaces within the hospital and in the event that there were no available beds, staff would utilise the NHS Dumfries & Galloway Midpark Hospital Bed Management and Occupancy Escalation Plan discussed in domain 1.

National guidance, including Scottish Health Technical Memorandum (SHTM) 04-01 Water Safety for Healthcare Premises, states that NHS boards are required to have water safety systems in place for the control and management of risks posed by waterborne organisms that may cause disease including the regular flushing of infrequently used water outlets. We were advised that support services and estates staff were responsible for monitoring and managing water outlets. We reviewed records relating to the flushing of infrequently used water outlets and found these were being completed in accordance with NHS Dumfries & Galloway's water safety policy.

Areas of good practice

Domain 4.1	
6	Centralised cafe allowed a space for relatives to meet and was a welcoming environment.
7	Within the older adult wards, movement sensors were used to alert staff when patients mobilised independently, supporting falls prevention while avoiding more restrictive interventions such as continuous observation.

Requirements

Domain 4.1	
5	NHS Dumfries & Galloway must ensure implement and maintain effective systems to ensure that current Mental Health (Care and Treatment) (Scotland) Act 2003 documentation is easily accessible to all relevant staff.
6	NHS Dumfries & Galloway must ensure effective completion of ligature risk assessments and any identified risks to ensure these are effectively mitigated and underpinned by an agreed organisational ligature policy.

7	NHS Dumfries & Galloway must ensure all areas within wards are risk assessed to identify and mitigate any risks associated with restricted lines of sight.
8	NHS Dumfries & Galloway must ensure robust fire safety management arrangements are in place, with identified fire risks supported by documented risk assessments, mitigation measures and available action plans. Staff should understand their role the management of fire safety risks.
9	NHS Dumfries & Galloway must ensure when patients require seclusion it is implemented and documented consistently across the service and underpinned by an agreed organisational seclusion policy.

Domain 4.3 – Workforce planning

Quality indicator 4.3 – Workforce planning

We observed patients receiving person centred care delivered with compassion and respect. NHS Dumfries & Galloway demonstrated effective workforce planning arrangements, supported by a digital staffing management system, positive staff wellbeing initiatives and a supportive learning environment for students. However, areas for improvement relate to leadership capacity, staff supervision, and induction materials.

NHS Dumfries & Galloway uses a digital workforce management system to provide oversight of staffing levels, patient acuity and dependency across clinical areas. During the inspection, we reviewed staffing levels, skill mix, escalation processes and workforce pressures across a range of wards. Staff who spoke with inspectors described being confident in the use of the system.

The electronic workforce management system provides a red, amber, green and grey (RAGG) rating to monitor staffing levels against patient acuity, dependency and professional judgement. This provides a structured approach to identifying, escalating and managing staffing risk.

Evidence reviewed demonstrated that NHS Dumfries & Galloway was using the workforce management system effectively. Clinical teams routinely used the professional judgement function escalation concerns relating to staffing levels, skill mix and workforce pressures. Inspectors also observed that staffing escalations and associated mitigation measures including staff redeployment and the use of bank staff were clearly documented. This provided assurance that staffing risks were being identified, monitoring and managed appropriately.

Workforce data submitted by NHS Dumfries & Galloway demonstrated no significant nursing vacancy rate within Midpark Hospital. Across the six wards the average nursing vacancy rate was 8.8%, which is below the level generally considered to represent a high vacancy rate of 10%. The average sickness absence rate across the six wards is 3.1% which is below the predicted annual sickness absence rate of 3.5% for Midpark Hospital.

Predicted absence allowance is the percentage of hours built into establishments to account for planned and unplanned absence of staff. While the national recommended allowance is 22.5%, evidence submitted by NHS Dumfries & Galloway showed actual absence levels of 28.1 % largely due to sickness and annual leave.

Recruitment challenges in filling a second dietitian post had resulted in an increased caseload for the dietitian currently in post. This risk had been recorded on the risk register. At the time of inspection, the post had been successfully recruited to, and the risk was expected to be removed. Staff reported continued access to dietetic input when required and did not identify any concerns regarding waiting times.

The Common Staffing Method supports NHS boards to assess staffing requirements using a triangulated approach that considers workload, professional judgement and quality measures. The Health and Care (Staffing) (Scotland) Act 2019 commenced on 1 April 2024. It stipulates that NHS boards have a duty to annually apply the Common Staffing Method, which includes a staffing level tool run and requires this to be applied rigorously and consistently. The application of the common staffing method and associated staffing level tools supports NHS boards to ensure appropriate staffing, the health, wellbeing and safety of patients and the provision of safe and high-quality care. Evidence reviewed demonstrated that staffing reviews had been completed and Common Staffing Method reports for all wards provided a comprehensive overview of ward staffing establishments, staffing requirements and associated risks. Inspectors were assured that the Common Staffing Method for all wards was being applied in line with legislative requirements.

Time to lead is a legislative requirement under the Health Care Staffing (Scotland) Act 2019 and is intended to enable clinical leaders to provide and oversee the delivery of safe, high quality and person-centred care. Senior charge nurses advised inspectors that they were allocated three days a week for time to lead activities. This demonstrated the breadth of responsibilities undertaken by senior nursing staff, who provided both clinical leadership and operational support across the service.

At the time of our onsite inspection one ward had a vacancy for a temporary senior charge nurse. Senior managers advised that the post was advertised however there had been limited interest. In the interim, leadership responsibility had been provided by a senior charge nurse from another ward. However, at the time of inspection, the senior charge nurse providing this cover was on leave. Inspectors were advised that the agreed staffing level was 3 registered nurses per shift however there was only one registered nurse on duty in this ward who was also required to provide support with medication administration on another ward which was also short. As a result, there was limited ward leadership present and oversight within the ward during the inspection. During periods of absence, including annual leave, staff reported that support and escalation routes were available through the Nominated Hospital Lead.

Clinical supervision is a proactive process to support development and professional growth by offering dedicated time, feedback, and guidance in a psychologically safe

space to enable staff to critically reflect on practice. Staff on one ward advised inspectors that formal supervision was not consistently taking place and there could be prolonged periods of time without a supervision session. However, staff reported feeling comfortable approaching their senior colleagues for support outside of formal supervision arrangements. Evidence provided demonstrated that appraisal compliance was generally high, with most wards achieving rates above 90%. Appraisals provide a structured opportunity to review performance, agree objectives and identify development needs.

In contrast, supervision compliance ranged from 17% to 66%. Effective supervision is essential to support staff wellbeing, professional development and safe clinical practice. The low supervision rates identified could indicate that staff were not receiving regular opportunities for reflection and support. A recommendation has been given to support improvement in this area.

Staff we spoke with who had physical health conditions reported that duty rosters were adjusted to accommodate their needs while maintaining an appropriate skill mix. Staff reported feeling well supported through the risk assessment process to maintain their safety at work. At the time of our onsite inspection one ward was trialling 12-hour shift patterns compared to the eight-hour pattern that had been in place. Staff reported feeling positive about the change and reported it has had a positive impact on staff morale.

However, staff described frequently being asked to move wards depending on the activity levels across the hospital. We were told although staff generally agree amongst themselves who will move, some staff reported feeling expected to work in unfamiliar environments and with unfamiliar patient groups, even when they lacked confidence in doing so. Inspectors observed at the huddle that there was oversight in relation to staff redeployment and the Nominated Hospital Lead was available to support staff in relation to any issues.

We discussed this with senior managers who acknowledged that ward staff were regularly deployed between wards to meet service needs and advised that a short quality improvement project was underway to better understand the staff experiences of ward redeployment. Whilst we recognise work already underway a requirement has therefore been made to support improvement in this area.

Inspectors discussed post incident support arrangements with ward staff who explained that a ‘hot debrief’ was undertaken immediately following incidents, with a subsequent ‘cold debrief’ offered to staff at a later stage. With support also available through psychology and spiritual care services. The majority of staff spoke positively about the support received following significant incidents and highlighted the value of input from the spiritual care services. However, one staff member reported limited access to formal debriefing opportunities despite being involved in a number of incidents during their employment. They advised that on occasion, opportunities for

debriefing had been affected by ward acuity and service pressures, with clinical demands often taking priority.

Effective induction and support arrangements are important in promoting staff wellbeing, competence and retention. Inspectors reviewed the Midpark Hospital New Staff Induction Programme which was last updated in April 2025. We found that a detailed induction programme was in place, providing staff with a broad introduction to the service and their role. Newly qualified nurses also had access to the Flying Start NHS programme, which supports the transition from student to registered practitioner through structured learning and development opportunities.

While the induction programme was comprehensive, some aspects required updating. We noted that it referenced IT systems that were no longer in use and included links to guidance that had since been superseded. Senior managers were aware of these issues and advised that the induction programme was scheduled for review later this year.

NHS Dumfries & Galloway has a range of resources in place to support staff wellbeing, which can be accessed through their Wellbeing Teams Hub Channel. This provides staff with access to information, wellbeing resources, training and community based support. Individual mental health support is also available through the staff psychology service. In addition, the spiritual care service provides compassionate support to both individual staff members and teams, including following challenging or distressing situations. This service also delivers staff awareness sessions on topics including trauma, self care and neurodiversity. Occupational health remains accessible when required, while staff can access Citizens Advice for financial guidance through NHS Dumfries & Galloway's Financial Wellbeing service.

Evidence provided highlighted a creative arts initiative designed to promote wellbeing. The Creative Arts in Healthcare programme 'Art Matters' provides artist led creative wellbeing sessions for both staff and patients at Midpark Hospital. Through activities such as clay and textile workshops, the programme promotes self expression, social connection and wellbeing. It also hosts a rolling exhibition in the hospital atrium, examples of which were observed during inspection.

Ward staff also spoke about a range of staff networks available to promote inclusion and peer support. These include staff support networks for people with ethnic minority backgrounds, disabled staff, LGBT+ staff and those with an interest in women's health. A dedicated network for men's health is also currently being established.

The Nursing and Midwifery Council (NMC) Standards for Student Supervision and Assessment outlines the roles and responsibilities of practice supervisors and assessors, ensuring that student nurses receive mentorship through high-quality support, and supervision during their practice placements. Students gave positive

feedback to inspectors about their placement experience and reported that they were well supported by staff.

Areas of good practice

Domain 4.3	
8	Psychology input to support staff through debriefs and one to one work when needed.
9	We observed staff demonstrating personalised, kind and caring interactions with patients.
10	Students provided positive feedback about their placement experience.
11	A comprehensive and accessible range of wellbeing services and peer support networks are available to support staff health, wellbeing and inclusion.

Recommendation

Domain 4.3	
2	NHS Dumfries & Galloway should support staff through regular clinical supervision.

Requirement

Domain 4.3	
10	NHS Dumfries & Galloway must ensure effective systems are in place to support staff when working in an unfamiliar area.

Domain 6 – Dignity and respect

Quality indicator 6.2 – Dignity and respect

Patients and carers we spoke with were positive about the care provided within Midpark Hospital and described staff as caring, approachable and supportive. However, improvements are required in the delivery of meaningful activity to enhance recovery and promote wellbeing.

Patients we were able to speak with were positive about the care and treatment they received. They described staff as caring, approachable and helpful and reported having access to advocacy services, which provide independent support to help people express their views, understand their rights and participate in decisions about their care and treatment. Patients also spoke positively about opportunities to participate in outdoor activities such as cycling and walking groups. However, one patient told us they were unable to participate in some third sector activities due to physical health restrictions and felt this resulted in long periods without meaningful occupation.

Carers we were able to talk with told us they were satisfied with their relatives' care and felt able to discuss issues with staff. While positive about the care provided, carers expressed some concerns regarding the availability of daily activities. They particularly valued the opportunity to meet relatives off the ward within the Hub cafe.

NHS Dumfries & Galloway obtains feedback from patients and carers through a range of mechanisms, including Care Opinion and QR code feedback included within discharge documentation. Care Opinion is an independent online platform that enables people to share their experiences of health and care services. Inspectors reviewed evidence demonstrating that feedback and complaints were discussed within Mental Health Governance and Development meeting. We saw an example of feedback from a recent Mental Welfare Commission visit being shared through the staff newsletter.

In May 2026 NHS Scotland's chief operating officer, chief nursing officer and chief medical officer wrote to all NHS Boards across Scotland to remind them of the requirement to adhere to national guidance on the Elimination of Mixed Sex Accommodation, to ensure patients are treated with dignity and respect, maintaining patient confidence, promoting privacy, and upholding the highest standards of care. Midpark Hospital provides single ensuite bedrooms across all wards. However, the wards operate as mixed sex environments, with male and female patients sharing communal areas such as dining areas and therapeutic spaces.

While Midpark Hospital is utilising the National Sexual Safety Collaborative standards to benchmark and guide future policy, NHS Dumfries & Galloway does not have a sexual safety policy or risk assessment. Staff advised that patient placement decisions are informed by individual risk assessment and professional judgement. The development of a formal policy and associated risk assessment would further support consistency in the management and oversight of sexual safety risks within mixed sex ward environments. Senior managers advised that work was underway to develop a policy due by the end of 2026. We did not observe any incident reports recorded in the three months prior to inspection in relation to harm from mixed sex accommodation. A requirement has been given to support improvement in this area.

Patients had access to quiet areas within the ward and outdoor space was accessible in all wards. On one ward inspectors observed that an outdoor gym funded through charitable donations was unavailable due to overgrown grass. We discussed this with staff when on site who reported that it related to grounds maintenance issues. Senior managers advised it has been escalated through the health and safety group. A recommendation has been given in relation to this.

We observed a range of third sector organisations providing therapeutic and recreational activities across Midpark Hospital and ward staff running occasional groups such as coping skills. However, there was limited evidence of a programme of therapeutic activities routinely provided by ward staff outwith the third sector contributions. Feedback from some patients and carers indicated that opportunities for meaningful occupation could be improved. The provision of meaningful activity on mental health wards increases social connectedness, improve psychological wellbeing and is essential to promote wellbeing and recovery. Inspectors also observed periods where several staff were seated in the communal ward area with limited visible

therapeutic engagement taking place. A requirement has been given to support improvement in this area.

Recommendation

Domain 6	
3	NHS Dumfries & Galloway should consider improvement of the outdoor area for patients within Midpark Hospital to develop a more accessible therapeutic space.

Requirements

Domain 6	
11	NHS Dumfries & Galloway must ensure work towards the elimination of mixed sex accommodation, and that effective systems and process are in place to: • uphold the highest standards of care, and • ensure adult support and protection issues are always effectively assessed.
12	NHS Dumfries & Galloway must ensure adequate staffing to enable meaningful activity to be provided to enhance recovery and promote wellbeing.

Appendix 1 - List of national guidance

The following national standards, guidance and best practice were current at the time of publication. This list is not exhaustive.

- Ageing and Frailty Standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland, November 2024)
- Allied Health Professions (AHP) Standards (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, September 2024
- A National Framework for Reviewing and Learning from Adverse Events in NHS Scotland (Healthcare Improvement Scotland, February 2025)
- Clinical Governance Standards (Healthcare Improvement Scotland, February 2026)
- Core Mental Health Quality Standard (Scottish Government, September 2023)
- Delivering Together for a Stronger Nursing and Midwifery Workforce (Scottish Government, February 2025)
- Fire Scotland Act (Acts of the Scottish Parliament, 2005)
- Food, fluid and nutritional care standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland, November 2014)
- From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care (Healthcare Improvement Scotland, January 2019)
- Generic Medical Record Keeping Standards (Royal College of Physicians, November 2009)
- Health and Care (Staffing) (Scotland) Act (Acts of the Scottish Parliament, 2019)
- Health and Social Care Standards (Scottish Government, June 2017)
- Healthcare Improvement Scotland and Scottish Government: operating framework (Healthcare Improvement Scotland, November 2022)
- Infection prevention and control standards – Healthcare Improvement Scotland Healthcare Improvement Scotland, May 2022)
- Mental Health (Care and Treatment) (Scotland) Act (Acts of the Scottish Parliament, 2003)
- National Infection Prevention and Control Manual (NHS National Services Scotland, January 2024)
- NHS Scotland Assure Mental Health Built Environment Quality and Safety Assessment Toolkit Health Building Notice 03-01 Adult acute mental health units (Health Facilities Scotland, 2014)
- Prevention and Management of Pressure Ulcers - Standards (Healthcare Improvement Scotland, October 2020)
- Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society and Royal College of Nursing, January 2019)

- Rights, risks, and limits to freedom (Mental Welfare Commission, May 2025)
- Standards for student supervision and assessment (Nursing & Midwifery Council, April 2023)
- The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, October 2018)
- The quality assurance system and framework – Healthcare Improvement Scotland (Healthcare Improvement Scotland, September 2022)

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