

Mental Welfare Commission for Scotland

Report on announced visit to: The Kingsway Care Centre,
King's Cross Road, Dundee DD2 3PT

Date of visit: 24 April 2018

Where we visited

The Kingsway Care Centre is an old age psychiatry facility in Dundee, with 55 beds in total. There are four wards in the care centre: Ward 1 has 15 beds and is an admission/assessment ward for female patients with dementia; Ward 2 has 12 beds, and is a male dementia assessment ward; Ward 3 has 14 beds and is a specialist dementia care ward for male and female patients with dementia; Ward 4 has 14 beds and is an admission/assessment ward for male and female patients with a functional illness.

We last visited this service on 28 September 2016, when we made recommendations about displaying information, and about the physical environment in the wards. We received a response which indicated that appropriate actions were taken in relation to the recommendations.

On the day of this visit we wanted to look generally at how care and treatment was being provided, because it had been a year and a half since our previous visit.

Who we met with

We met with and/or reviewed the care and treatment of 15 patients, and we also met two relatives on the visit.

We spoke with the service managers and various members of the nursing team in the four wards. We met one of the consultant psychiatrists and the pharmacist, and one of the activity workers working in the service.

Commission visitors

Ian Cairns, Social Work Officer and visit coordinator

Claire Lamza, Nursing Officer

Paula John, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

Where we were able to have discussions with patients about their experience of care and treatment in the wards, they spoke positively about the support they are receiving. Both relatives we met were also complementary about staff in the wards, and about the communication between themselves and staff. We also observed during the day that the atmosphere in the wards was calm and quiet, with good interactions between staff and patients, including with patients who were displaying some stressed or distressed behaviour.

The care plans we reviewed across all four wards were of a good standard. Information in care plans was consistently comprehensive and person centred.

We saw good use being made of psychological formulation, a framework for describing an individual patient's needs, any precipitating factors contributing to needs, and interventions to meet needs. We also saw that it was easy to identify care planning information in files, because paperwork is colour coded, with risk management plans in green and multidisciplinary team reviews on yellow paper.

We saw evidence of a robust evaluation of care plans, and we also noted an emphasis in individual files on recovery based approaches. We saw some recovery care plans in files, and we heard about work to develop a care plan audit approach based on the Scottish Recovery Indicator (SRI2), a service development tool which provides a framework for evaluating how services are performing. We also saw examples of detailed guidance in individual files provided for ward staff by a psychologist following an assessment, to help staff managing stressed/distressed behaviours.

Multidisciplinary team (MDT) meetings are well recorded, and as stated above are easily identifiable because they are colour coded. There seems to be good input from all relevant professions to the MDT meetings. The reviews seem to cover all appropriate aspects of individual patients' care, including physical and mental health, nutrition, mobility and medication.

The care planning and MDT information is complemented by good information, which is recorded about the individual patients in Getting to Know Me and My Life Story forms. We also saw good information about communication with relatives and family members, with records in carers contact sheets in files. For example, which detailed discussions with family members about how involved they wanted to be in discussions about care and treatment.

We did notice that a number of patients were prescribed medication which could be administered 'as required' for agitation, and that the drug prescription sheets indicated that this medication was not being used in many cases. We discussed this issue at the end of the visit with managers, and we were told that there has been a focus in the wards on reducing the use of 'as required' medication for agitation. We would suggest that if medication prescribed on an 'as required' basis has not been administered, this could be reviewed at the MDT meetings, and this medication could be removed from drug prescription sheets, if it is felt that this is no longer required.

Use of mental health and incapacity legislation

A number of patients in the four wards were subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act). Mental Health Act paperwork was well maintained in the files we reviewed. Where patients were subject to compulsory measures, we also saw that, either consent to treatment certificate (T2) or certificate authorising treatment (T3) were in place, and that prescribed medication was authorised appropriately.

A number of patients had welfare guardians or attorneys in place, appointed under the Adults with Incapacity (Scotland) Act 2000 (AWI Act). We saw copies of guardianship orders or powers of attorney in files, and we felt there was clear evidence that staff are asking relatives to provide copies of any orders granted under the AWI Act.

Where individuals are assessed as lacking capacity to consent to treatment, and they are being provided with treatment under part 5 of the AWI Act, s47 certificates authorising treatment should be completed. We were pleased to see copies of s47 certificates with appropriate treatment plans in the files we reviewed.

Rights and restrictions

From our review of files, we were satisfied that compulsory measures under the Mental Health Act are being put in place when this is appropriate. We feel this is important, as legislation provides certain safeguards when compulsory measures are in place for the provision of care and treatment.

In a few files, we noted that covert medication was being administered. We saw that covert medication pathways were being completed, and that decisions about use of covert medication were reviewed regularly.

Activity and occupation

From the evidence, we saw on this visit there is good provision of activities across the wards. We saw timetables with regular planned group activities, including groups encouraging patients to participate in exercises. We also saw evidence of more personalised one-to-one activity provision, with activities arranged by dedicated activity workers in the wards, and also by occupational therapy and physiotherapy staff and by ward based nursing staff.

With regard to individual patient participation in activities, we saw that this was recorded in the daily contact section of the patient's electronic record. It was difficult to find information about when an individual had been encouraged to engage in activities but had opted not to do so. We would suggest that this could be covered briefly in the MDT review meeting, so that engagement in activities could be tracked and monitored easily.

The physical environment

All patients in the four wards have their own individual rooms with en-suite facilities. Some wards have more communal space than others, and Ward 4 in particular has more limited lounge space and space for activities. All wards have access to garden areas.

In the three dementia wards, wards 1, 2 and 3, we saw that a lot of work had been done to make the environments dementia friendly. We saw rummage boxes, which can be used as an activity and as a reminiscence tool. We saw memory boxes as well

outside bedrooms. We also saw distraction boards, and heard how specific items are put on boards to reflect an individual patient's background and work experience, and to provide individual patients with some stimulating activity using familiar objects.

We had noticed on our previous visit that nursing staff found it difficult to observe patients when they are in their rooms because of the design of the rooms. This can mean that if a patient is on an enhanced level of observation, nursing staff have to enter rooms when undertaking observations. This has been raised by staff in the wards and by managers as a potential patient safety risk, but no alterations have been made to any rooms in the care centre to allow staff to maintain special observation, when this is necessary, without entering a room. The Mental Welfare Commission feels that this is an issue which needs to be addressed by NHS Tayside. We would suggest that there should be a number of rooms available in each ward which have the facility to allow nursing staff to observe patients when enhanced observation is appropriate, without having to enter rooms, and to avoid disturbing patients unnecessarily overnight.

Recommendation 1:

Managers should ensure that arrangements are put in place so that a number of specific bedrooms in each ward have facilities to allow patient observation without staff having to enter bedrooms.

Summary of recommendations

1. Managers should ensure that arrangements are put in place so that a number of specific bedrooms in each ward have facilities to allow patient observation without staff having to enter bedrooms.

Good practice

On this visit Commission visitors were impressed by the emphasis within the wards on staff training and on reflective practice and learning. All student nurses in the centre were participating in a training event on the day of our visit, but we also felt there was a clear focus on practice development for permanent staff within the wards as well. We felt that there are very positive links between senior charge nurses and the practice development nurse, and we saw a specific examples of this during our visit. This was clear with the new care plan audit tool which is being developed, and with a number of other innovative practices, for example with a review of the role of the key worker and of communication with carers.

Service response to recommendations

The Commission requires a response to the above recommendation within three months of the date of this report.

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

Alison Thomson
Executive Director (Nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The MWC is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors. Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

Contact details:

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

telephone: 0131 313 8777

e-mail: enquiries@mwscot.org.uk

website: www.mwscot.org.uk

