Mental Welfare Commission for Scotland

Report on announced visit to:
Kingsway Care Centre, Ward 4, Kingscross Road, Dundee, DD2 3PT

Date of visit: 01 October 2024

Where we visited

Ward 4 is a 14-bedded, mixed-sex unit that provides care for older adults, typically aged 65 and older, who requirement assessment for a functional mental illness.

On the day of our visit, there were nine people on the ward and three vacant beds. We were told the 14 beds had been temporarily reduced to accommodate 12 people due to the ongoing anti-ligature work that was being carried out in two bedrooms.

We last visited this service in June 2023, on an unannounced visit and made recommendations that individuals, relatives and carers were involved in all aspects of care, that a system was put in place that would identify all individuals who required a T2 or T3 certificate to authorise their psychotropic treatment, that existing garden fencing was altered and that identified anti ligature work timescales were produced.

The response we received from the service was that the multidisciplinary team (MDT) meeting document had been adapted to acknowledge and encourage involvement of individuals, their relatives and carers to ensure that they were invited into meetings, and there was overall increased engagement with relatives and carers, with audits in place to monitor these changes. Family meetings were also taking place.

Responsible medical officers (RMOs) were including senior charge nurses in email correspondence about second opinion requests and visits.

An interim measure of tarpaulin to cover the existing fencing had been put in place for privacy reasons, however, there was ongoing discussion about putting fencing in place, as had been previously recommended. Anti ligature work timescales for all remaining 10 bedrooms have an estimated date of completion of June 2025. We were told the estimated timescale was due to external factors out with the jurisdiction of Kingsway Care Centre, where the site landlord was yet to grant approval for the proposed anti ligature work in the remaining bedrooms to proceed, and NHS Tayside's construction and development services were yet to decide on tender for contracted works.

On the day of this visit, we wanted to follow up on the previous recommendations and to hear how ward staff were managing risks considering the delayed anti ligature works. We were told service management/leadership regularly attended ligature anchor point reduction (LAPRA) meetings to keep updated with ongoing work and timescales, ward and staff adaptations were in place with increased floor nurse presence, high risk rooms used where necessary, and additional training with a focus on suicide awareness, safety planning and increased personal searches where appropriate had been delivered to support safety and security in the ward.

Who we met with

We met with, and reviewed the care of six people, six who we met with in person and five who we reviewed the care notes of. We also met with one relative.

We spoke with the service manager, the senior charge nurse, nursing staff, occupational therapist (OT), nursing assistants, and student nurses.

Commission visitors

Gordon McNelis, nursing officer

Tracey Ferguson, social work officer

Sandra Rae, social work officer

Kirsty MacLeod, engagement and participation officer (carers)

What people told us and what we found

The individuals we spoke with on the day of our visit gave positive comments about staff. We were told “staff are good”, with regards to one-to-one discussions and “If I want to talk, they’re always available” and that the “food is good”. We were also told that carers “felt involved with (their relatives) care and treatment”. We did hear some negative comments, where individuals told us that they felt their rooms “lacked privacy” due to no curtain/door in place between the bedroom and bathroom area.

Care, treatment, support, and participation

Care records

Information on individuals care and treatment was held electronically and easily located on the EMIS system.

Our review of these records found them to be of mixed quality, with some continuation notes giving the reader a detailed, clinical description of the individuals mental state and presentation, while others gave a basic account with frequent use of wording used to describe the individuals such as “settled” and “slept well”. We consider it is necessary for health professionals to be descriptive when recording clinical information and give a clear account of whether a person’s mental health is showing signs of improvement, deterioration or is unchanged.

We would also advise that there should be an increased amount of documented evidence to show the level of nursing staff engagement and interaction with individuals. On the day of the visit, we observed a warm, kind and caring engagement between nursing staff and the individuals in their care; documenting the rationale for contact, the individual’s reaction to this, their comments and views at that time is essential. This was discussed with senior staff and managers during our visit feedback session at the end of the day.

We found evidence of regular one-to-one discussion between individuals, when they meetings with nursing and medical staff took place. These were descriptive, meaningful; they linked with care plans and considered the views of the individual.

We wanted to follow up on our previous recommendation regarding relatives and carers involvement in all aspects of an individual’s care and treatment, where appropriate, including with care plans. We were pleased to see that the individuals’, their relatives and carers views were recorded and discussed further during MDT and family meetings.

We found nursing care plans linked with assessments at the point of admission and risk assessments; these outlined clear goals and interventions, which were person-centred, meaningful and regularly reviewed. However, some individuals we spoke with did not have a copy of, or had an awareness of, their care plans. We found a mixed account of individuals participating in developing their care plans. We

appreciate that for some, their ability to engage and contribute to care planning may be limited, depending on their illness however, we would have expected this to be acknowledged and documented with consideration. This would then have enabled engagement and participation in the care planning process to be revisited and for individuals to contribute when they were able to.

Recommendation 1:
Managers should ensure that individuals and their relatives (where appropriate) are involved in developing care plans, where possible. Their participation should be recorded in the care records, and they should be offered a copy of their care plans. If individuals chose not to or cannot be involved, this should be recorded.

We would also like to see documented evidence of individuals being offered a copy of their care plans with a record of whether they accepted these or not. We found discharge planning included the family and carers views, input from community mental health teams (CMHT), social work and additional recommendations from OT.

The Commission has published a good practice guide on care plans[1]. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

Multidisciplinary team (MDT)
A range of professionals were involved in the provision of care and treatment in the ward. This included psychiatry, nursing staff, health care support workers, OT and an activity support worker (ASW). Ward 4 had access to the psychology services that were based at Kingsway Care Centre. Ward staff referred individuals to this service when required. The ward had regular input from pharmacy who were available for guidance and advice, and they attended the ward regularly.

We were told of challenges that staff experienced with the increase in individuals who were under 65 years of age and coming from the general adult psychiatry (GAP) services, but who had met the threshold for admission to Ward 4. Staff have had to take into consideration the additional risks, not usually associated with the older adult group. This has prompted adaptations to the ward routine, with increased focus on additional safety plans, an increase in staff presence and observation of individuals on the ward.

We were told MDT meetings took place once per week which the individual and carer were invited to attend. In some records, we saw evidence of the attendees for these meetings, including regular attendance by the designated social worker, community psychiatric nurse (CPN) and the care home liaison team, who liaised with the ward leading up to and during the point of discharge. However, this was not consistently

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

recorded. We heard that advocacy had a good presence on the ward and although staff could support individuals to refer themselves to advocacy, the mental health officer (MHO) involved in a person's detention often referred individuals to advocacy on admission.

We found some of the documents that supported the MDT meetings had information missing, such as no clear record of attendance and the individual's 'summary of progress' section. Although we found nursing review sections contained information from the previous week, this was minimal and did not match with the detail provided in the individual's continuation notes entries.

Recommendation 2:
Managers should ensure that all MDT document sections are completed comprehensively.

We also found different MDT meeting templates, where some had a checkbox section to demonstrate that the individuals, carers and relatives' views had been gathered; other templates did not provide the opportunity to record this information. We were told the older templates had not included the checkbox section and that these were still in circulation and available for use in the ward.

Recommendation 3:
Managers should ensure that all older format MDT document templates should be taken out of circulation and newer templates used consistently.

Use of mental health and incapacity legislation

On the day of the visit, three people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) and two people were under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act).

All documentation relating to the Mental Health Act was in place and in good order however, documentation relating to the AWI Act was not easily found. We found no system in place to notify ward staff which individuals were subject to a welfare guardianship order or had nominated a power of attorney. When a welfare proxy, such as a power of attorney is in place for an individual and they have powers to decide about an individual's treatment, the AWI Act requires that they are consulted and asked for their consent to proceed with treatment.

Recommendation 4:
Managers should ensure a robust system is in place to notify ward staff that an individual is subject to a guardianship order or has a power of attorney.

Recommendation 5:
Managers must ensure welfare proxies who have powers to decide on medical treatment are consulted and their consent to proceed with treatment is obtained.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained and are either capable or incapable of consenting to specific treatments. On the day of our visit, we wanted to follow up on previous recommendations regarding consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act. We found these were easy to find, in good order and corresponded to the medication prescribed.

For individuals who had covert medication in place, we found the covert medication pathway paperwork completed, which included an easy-to-understand rationale and instruction from pharmacy and medical staff. We were pleased to find covert medication was regularly reviewed and discussed at MDT meetings.

Rights and restrictions

A locked door policy remains in place in Ward 4 to provide a safe environment and support the personal safety of everyone on the ward. Although we felt this was proportionate for a percentage of those who were detained, the rights of individuals who were admitted to the ward informally and who do not need a locked door must equally be fully considered, so that they can have free access to the outside world.

We were told informal inpatients were made aware of their rights to leave the ward in the ward's welcome pack and this was also discussed during admission. However, we were unable to find evidence of the locked door protocol being explained to individuals and the options they have regarding leaving the ward in the care records.

Recommendation 6:
Managers should ensure all individuals receiving care and treatment in Ward 4 are made aware of their rights with regards to locked door policy and these conversations should be documented in the care records.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We found one advance statement in a file, and were told this would be revised when the mental state of the individual improved. We also saw discussions about advance statements recorded in the care records.

Activity and occupation

Ward 4 had a good level of activity that was arranged by the designated OT and ASW to take place over a seven-day period. In addition to the therapeutic activities on offer, such as relaxation and mindfulness groups, there was focus and promotion of the links between physical activity and mental health. A range of exercises were available for individuals and ward staff to participate in, such as seated yoga,

recovery outings and walking groups in the community setting, as well as access to the ‘get out get active’ activity programme.

We heard complimentary comments from individuals about the variety and benefits of activities on offer and found that activities that had taken place were documented in the continuation notes, including a record of whether the individual had accepted or declined to participate.

The physical environment

Ward 4 was welcoming and bright; it had several colourful wall features that displayed positive messages and included artworks made by those on the ward. We saw visual prompts positioned throughout the ward that encouraged individuals to participate in mild exercise.

We wanted to follow up on our previous recommendation regarding altering the garden area fencing to provide privacy for the individuals who used it. We were told consideration was given to replacement fencing however, it was felt a more natural privacy area would be better achieved by planting garden bushes instead of fencing. At the time of visit, this had not been put in place and is an area that we feel should be actioned fully.

Recommendation 7:
Managers should ensure that the existing fencing in the garden area is altered to one which fits with this natural environment and provides privacy for individuals using the garden.

We wanted to follow up on our previous recommendation regarding the progress of the anti-ligature work on the ward. At the time of our visit, we saw work was being progressed to upgrade two side rooms to meet anti-ligature standards. We were told this was in week four of an expected a six-week timescale of completion.

Senior staff continued to attend LAPRA meetings and were updated on timescales and ongoing work. We saw safety precautions in place to separate ongoing renovations from the main body of the ward and to minimise disruption to the ward and individuals. We saw two high risk rooms in use, which complied with anti-ligature standards and enabled observation of an individual and the room, whilst promoting privacy. Dependant on the identified level of risk, these rooms could be adapted to suit an individual’s needs, such as removal of magnetic fixtures and fittings and installation of bed and chair sensors.

We were told the completion of anti-ligature renovation to the remaining bedrooms would remain ongoing with an expected timescale of completion by mid-2025. We will keep this under review.

Summary of recommendations

Recommendation 1:
Managers should ensure that individuals and their relatives (where appropriate) are involved in developing care plans, where possible. Their participation should be recorded in the care records, and they should be offered a copy of their care plans. If individuals choose not to or cannot be involved, this should be recorded.

Recommendation 2:
Managers should ensure that all MDT document sections are completed comprehensively.

Recommendation 3:
Managers should ensure that all older format MDT document templates should be taken out of circulation and newer templates used consistently.

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Managers should ensure a robust system is in place to notify ward staff that an individual is subject to a guardianship order or has a power of attorney.

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Managers must ensure welfare proxies who have powers to decide on medical treatment are consulted and their consent to proceed with treatment is obtained.

Recommendation 6:
Managers should ensure all individuals receiving care and treatment in Ward 4 are made aware of their rights with regards to locked door policy and these conversations should be documented in the care records.

Recommendation 7:
Managers should ensure the existing fencing in the garden area is altered to one which fits with this natural environment and provides privacy for individuals using the garden.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

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

The Commission visits people in a variety of settings.

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

When we visit:

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

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

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports, and Her Majesty's Inspectorate of Prisons inspection reports.

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

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

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

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

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

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