Mental Welfare Commission for Scotland

Report on announced visit to:
Kingsway Care Centre, Ward 1 and Ward 3, King's Cross Road, Dundee, DD2 3PT

Date of visit: 22 May 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice, and known good practice e.g. the Commission's good practice guides.

Where we visited

The Kingsway Care Centre is an old age psychiatry facility in Dundee. There are three wards in the centre. Ward 1 and Ward 3 were in the same building, with a further ward in another area of the site.

Both Ward 1 and Ward 3 are 12-bedded assessment wards for males and females who are over the age of 65. The wards provide care for individuals with, or who are being assessed for an organic brain disorder. On the day of our visit there were no vacant beds in either of the wards.

We last visited both wards individually in September 2023 and made recommendations for each.

There was one recommendation for Ward 1 where we recommended that staff from the multidisciplinary team (MDT) should ensure that all sections of documentation of the MDT meeting were fully completed to reflect each individual's ongoing plans, goals, and next steps of their journey.

There were three recommendations in Ward 3, which included that the MDT meeting records clearly document attendance, discussions, decisions taken, actions and who was responsible for these actions. We recommended that further training should be provided for medical practitioners in relation to the completion of section 47 treatment plans, in accordance with Adults with Incapacity (Scotland) Act, 2000 code of practice. The final recommendation was that the fencing in the garden area should be replaced to allow for a greater privacy for individuals and their relatives.

For this visit, we wanted to meet with people receiving care and treatment, review their care records, follow up on the previous recommendations for each ward and discuss progress on the detailed action plans that were sent to us.

Who we met with

In Ward 1, we met with five people and reviewed their care records along with another care record of one other person. We also spoke with two relatives.

In Ward 3, we met with five people and reviewed the care records of four of them. We met with two relatives.

We spoke with nursing and other ward-based staff, the speciality manager (SM), the clinical nurse manager (CNM) and both senior charge nurses (SCNs).

Commission visitors

Sandra Rae, social work officer

Tracy Ferguson, social work officer

Denise McLellan, nursing officer

Gordon McNelis, nursing officer

What people told us and what we found

Care, treatment, support, and participation

Some of the people we met with from both Ward 1 and Ward 3 were able to share their experiences of the care and treatment they have received.

Those that were able to talk with us told us that staff were “very nice and helpful” and “staff were happy to help”; we heard “the food was good”. We saw positive interactions between individuals and staff in both wards, with them appearing at ease in each other’s company.

Due to the level of cognitive impairment, we were unable to have detailed conversations with people in the wards. However, some people were able to tell us that they were well looked after and felt safe. We were able to see the activities they engaged in and observe the interactions between staff and individuals on both wards which confirmed this.

We found these interactions to be positive, warm, caring, and respectful. Staff we spoke with knew the individuals well. We were pleased to see that efforts had been made to support people in both wards with their personal care, encouraging them to wear items that were of significance to them.

Staff also ensured people were able to have personal belongings in their bedrooms, with pictures and photographs placed in bedrooms that were on display for people to see.

The feedback from families/relatives was positive in both wards however, two relatives advised us that they felt communication with ward staff in both Ward 1 and Ward 3 could be improved. We were informed they were not invited to the weekly ward meetings although they were contacted by the responsible medical officer (RMO) as needed and they could speak with nursing staff out with this, if any issues arose. We discussed this with the SCNs, who told us that the MDT members would continue to work with families to improve the level of communication.

We heard that Ward 3 have participated in a ‘Triangle of Care’ quality improvement project with Health Improvement Scotland and were actively working to support carers and families with care planning during the assessment process.

Other relatives provided feedback about the high standards of care in the wards and felt that they were listened to. We also heard from other relatives in both wards that they were regularly kept up to date and had been invited to the MDT. We were reassured to hear that across both wards, most relatives felt “heard”, that “care, and treatment was excellent” and “the whole staff team are pleasant.”

We also heard that relatives were comfortable raising issues with the SCN, and other staff. Relatives told us that their family members had settled in well due to the staff "input and dedication" and involvement from them at the admission stage had ensured that all of the relevant information was passed on relating to the progress of their relative's illness.

We did hear from a relative that they were disappointed by the lack of social work input, which they felt could have prevented admission to hospital for their relative.

Care records

Information about the care and treatment of those in both wards was held on the electronic record system, EMIS. In addition to this, individual care plans and other information was held in paper format. This enabled staff who did not have access to EMIS prompt access to specific information about the people they were caring for.

We found on both wards that information relating to an individual's assessment, their care plans, the MDT meeting records, and risk assessments were easy to find, well organised, regularly updated and reviewed. There was a named nurse system was in place and records kept of staff engagement with individuals in one-to-one meetings that were descriptive and detailed.

We found person-centred care plans that were individualised, strengths-based and included protective factors. They addressed a wide range of care needs including those for mental and physical health. There were detailed stress and distress care plans and others that covered the health and wellbeing of the individual.

The care record contained 'Getting to know me' (GTKM) documentation, showing family/carer involvement, which promoted opportunities for individuals' wishes and preferences to be realised, in conjunction with helping to inform care planning. There was also the Dementia UK 'my life story' document that had been completed.

We found 'do not attempt cardiopulmonary resuscitation' (DNACPR) documentation in place, where appropriate, and evidence of family and legal proxy involvement in both wards. We saw information on the requirement of a locked door and care plans relating to the person's legal status that had been discussed, where possible, with individuals and their carers, on both wards.

We heard there was a robust care plan audit process in place across both Ward 1 and Ward 3. We also heard that more detailed audits of the quality of the documentation took place, which were then used as learning and development opportunities for staff.

For individuals on both wards, we observed that physical healthcare needs were robustly managed. We were pleased to hear that the wards had a dedicated junior doctor who was primarily responsible for managing physical health needs. All

individuals admitted to the wards received a full physical health review which was completed on an ongoing basis, in line with medication changes or any change of presentation. Assessments of the national early warning score (NEWS) were completed weekly to monitor and improve outcomes for individuals on the wards. These were carried out more frequently, dependent on each person's needs. In addition, if individuals remained on either ward for one year or more, full annual physical health checks took place.

Delayed discharge is a term used when a person is medically fit to leave hospital, however, they are unable to leave due to non-medical factors. This usually means there is a lack of appropriate care or services available such as a care home placement or where there are difficulties coordinating care. It can also be a result of there being no legal proxy in place to support the person to move from hospital to another care facility, specifically when they do not wish to move there.

During our visit there was one individual from one of the wards whose discharge was delayed due to a lack of suitable care home placement. We heard that most people in Ward 3 were relatively new to the ward and were still in the assessment process.

Multidisciplinary team (MDT)
Each of the wards had an MDT on site consisting of a nursing team, medical staff, a ward-based activity support worker (ASW), a psychiatrist, a rotational resident doctor, occupational therapist (OT) support, dietetic provision as well as colleagues from pharmacy and physiotherapy.

Weekly MDT meetings took place to review the individuals in each ward. We also heard that the MDTs had useful links with the community mental health team (CMHT) and access to social work. Kingsway Care Centre benefitted from having both a care home liaison service and a post diagnostic team which had supported discharges and provided ongoing support for people in the community settings after discharge.

While there were weekly MDT meetings on both wards, these differed in relation to how the information was collated and stored.

In Ward 1, we reviewed MDT meeting records on EMIS and found a consistent approach to recording details from the meetings, with reference to earlier meetings and progress made or changes needed. The meeting template guided discussion in key areas such as admission, legislation, risk, medication, diagnosis, physical health, time off the ward and the family/carer perspective. There was a clear focus on consulting with families.

In Ward 3, the approach to recording the MDT meeting was less clear from the records, which were still not recorded on EMIS. The MDT records were in paper format and were often brief. The MDT meeting records lacked clarity of who was

involved in an individual's care and treatment. Information on who had been invited to attend the meeting was not always completed, nor was who was responsible for providing the update to the individual or for taking action points forward. The MDT meeting record lacked detail on whether families and carers were given an opportunity to attend. We were told that families were informed of changes to care and treatment on an individual basis following MDT review. We could see evidence of collaborative working and communication with professionals, individuals and families in the care records, but this was lacking in the MDT meeting records.

We were disappointed to find that an earlier recommendation for Ward 3, which was made in 2023, for managers to ensure that MDT meeting records clearly documented attendance, discussions, decisions taken, actions to be taken and who had responsibility for these, remained unmet. An action plan had been submitted to the Commission in December 2023, advising us that the recommendation had been completed stating that the "MDT sheet from another ward was to be used within organic wards and yellow paper sheets to be removed allowing for the MDT meetings to be a live document on EMIS easily accessible with the relevant information required from the Commission visit."

We discussed this at our end of visit feedback session and were told that a decision had been taken by managers after the submission of the action plan not to introduce the changes. Managers felt it would be more beneficial to wait until the new electronic system, MORSE was in place instead of making two changes. We were told the transition to MORSE would be in August 2025 and that this would deliver the improvement in the MDT record, and where it would be easier to provide access to information. We are therefore repeating this recommendation.

Recommendation 1:
Managers must ensure that MDT meeting records in Ward 3 clearly document attendance, discussions, decisions taken, actions and who has responsibility for these actions.

We heard both ASWs from Ward 1 and Ward 3 were on leave so nursing staff were taking an active role in delivering meaningful activities each day, which was evident during our visit to both wards.

Use of mental health and incapacity legislation

On the day of our visit, eight people in Ward 1 were detained under compulsory measures in accordance with the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). In Ward 3, there were 11 people detained under the Mental Health Act. Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who were either capable or incapable of consenting to specific treatments.

When reviewing the records on both wards, we found the electronic medications kardex stored on the hospital electronic prescribing and medicines administration (HEPMA) online system. Information was also stored in paper format and kept in the treatment room for ease of dispensing medication.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act 2000 (the AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that treatment follows the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

In Ward 3, we found T3 certificates authorising treatment under the Mental Health Act were in place where needed and corresponded to the medication being prescribed. We also found that all section 47 treatment plans were detailed, clear and included discussion with the welfare proxy where appropriate. We found all documentation relating to the AWI Act, such as welfare guardianship orders and power of attorney documentation to be in place, as was all detention paperwork.

In Ward 1, we were disappointed to find that T3 certificates authorising treatment under the Mental Health Act were not always in place and we were concerned that in some circumstances, medication had not being prescribed lawfully. In Ward 1, we did find all documentation relating to the AWI Act, such as welfare guardianship orders, power of attorney documentation, section 47 certificates and detailed treatment plans to be in order. However, the folder was in a state of disarray with two section 47 certificates for some people and three for one person.

Recommendation 2:
Managers should ensure all psychotropic treatment under the Mental Health Act is legally authorised in Ward 1 and a robust auditing system is introduced across both wards to ensure compliance with this. This audit should include certificates around capacity to consent to treatment, and authority to treat under the AWI Act, when required.

Anybody who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. We were informed that in both wards there had been no nominated named person. We heard how staff still promoted this to ensure the person's rights were upheld.

Rights and restrictions

We found a locked door policy in both Ward 1 and Ward 3. This was necessary to provide a safe environment and support the personal safety of the individuals. We found locked door care plans for people in both wards, which were proportionate. We

were told the locked door protocol was reviewed on an ongoing basis and discussed with the person and their family or welfare proxy on admission.

When we were reviewing care records, we looked 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 were told staff from both wards encouraged individuals to have an advance statement by promoting them during the various stages of the admission. We heard and recognised this could be difficult due to the level of cognitive impairment for many of the individuals. Reminders were also included in the ward discharge checklist document and CMHTs were encouraged to follow this up with individuals following discharge. However, despite these efforts, there were no advance statements in place across either ward.

We heard the advocacy service visited all individuals in both wards, and access was available by self-referral or by nursing staff identifying a need and then encouraging and supporting the individual to arrange contact with them.

The Commission has developed *Rights in Mind.*[1] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

We saw examples of detailed activity plans on both wards. On the day of the visit neither ward had an ASW on site. We saw nursing staff facilitating activities in the dedicated activity rooms and main lounge areas on both wards.

We were able to see the challenges in encouraging some people to participate in the activities due to their cognitive decline and their wish to purposefully walk for extended periods. We saw others who were happy to engage in activities that did not challenge them physically, such as art and nail painting. We heard that hair styling was also a popular activity with the females.

We heard completing puzzles, card games and reminiscing were popular with both males and females. It was clear from our observation on the day that activities were taking place, but these were not always being recorded in detail, including if activities were offered but declined; we would expect this to be documented. We noticed that while there was good care planning around activities, it was not always clear how this took place for individuals, on a day-to-day basis on the ward.

[1] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

We also heard the OT staff provided individualised, structured assessments and therapeutic activities in both wards, which promoted skills that were transferable on discharge from hospital. These were clearly recorded in care records.

The physical environment

The layout of each ward comprised of 12 single ensuite rooms. We were pleased to hear all initial anti ligature work had been completed in both wards and individual patient and environmental risk assessments are completed to ensure patient safety.

The wards each had a lounge area, a separate dining room and an activity room. All were brightly decorated and spacious. Both environments were immaculate, with a calm and relaxed atmosphere. We were able to see the hard work from staff teams to soften the public rooms and the hall and corridor walls had been thoughtfully designed.

In Ward 3, we were pleased to see the creativity of the staff. We saw border details with wildflowers and wildlife along the long corridors. These were positioned as a way of orientation along the longer part of the walls. We heard this was implemented after studying dementia standards. The standards had informed how visual effects and textures could support individuals to be orientated around the ward in a safer way that could reduce the likelihood of falls.

In Ward 1, the artwork in the corridor area was lovely and brightened the ward. The corridor area is where we saw people purposefully walk and stop and look at the artwork. We heard that this work had been taken forward by a local artist as Ward 1 had successfully applied for and been granted monies, to improve the main corridor in the ward. The project was completed in conjunction with the NHS Charitable Foundation, Tayside Healthcare Arts Trust, and a commissioned local artist.

One of the other recommendations that had been made from our last visit to Ward 3 was that the bamboo fencing in the garden area should be replaced with an alternative, more weather resistant material to allow for a greater deal of privacy for individuals and their relatives who choose to use this therapeutic space. We found no progress had been made in this area.

The Commission received an action plan for Ward 3 in December 2023, saying that the gardeners had been contacted and “have agreed to utilise natural bushes to allow for privacy and while this takes shape green covering will be secured to provide a degree of privacy”. This has not been actioned, so the recommendation will be repeated. We also found the garden area in Ward 1 to be open, lacking privacy and requiring to be upgraded alongside Ward 3.

Recommendation 3:
The fencing in the garden areas of both Ward 1 and 3 should be replaced with an alternative, more weather resistant material to allow for a greater deal of privacy for individuals and their relatives who choose to use this therapeutic space.

We were pleased to have heard during our visit and at the end of day meeting with the SCNs and managers that the SCN in Ward 1 had recently applied for funding to significantly improve and upgrade all the Kingsway Care Centre garden areas. They were awaiting a decision to be made by the Charitable Foundation about the application. We were of the view however that this should have actioned in 2023 when the recommendation was made and action plan returned.

During our visit to Ward 3, we saw areas that required general maintenance which contributed to safety hazards and presented an increased risk to individuals and staff. There had been water damage to the treatment room, where medication was dispensed and treatment given. This had been left untreated for some time. We raised this with staff who told us this had been escalated to the external property and facilities management provider some time ago but had not been actioned. We also found a malodorous smell from a bedroom that had been treated for water damage and was being occupied by an individual. We heard the damage had been dealt with and the smell may have been due to the room having been unoccupied for a period; we asked that this be revisited and examined.

Recommendation 4:
Managers and property and facilities onsite response should ensure outstanding repair and refurbishment work in Ward 3 is undertaken in a timely manner and as soon as is practicable.

Summary of recommendations

Recommendation 1:
Managers must ensure that MDT meeting records in Ward 3 clearly document attendance, discussions, decisions taken, actions and who has responsibility for these actions.

Recommendation 2:
Managers should ensure all psychotropic treatment under the Mental Health Act is legally authorised in Ward 1 and a robust auditing system is introduced across both wards to ensure compliance with this. This audit should include certificates around capacity to consent to treatment, and authority to treat under the AWI Act, when required.

Recommendation 3:
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Recommendation 4:
Managers and property and facilities onsite response should ensure outstanding repair and refurbishment work in Ward 3 is undertaken in a timely manner and as soon as is practicable.

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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