Mental Welfare Commission for Scotland

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

Date of visit: 22 January 2026

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

Ward 4 is a 12-bedded, mixed-sex unit that provides care for older adults, usually aged 65 years and over, who require assessment and treatment relating to functional mental illness.

On the day of our visit, there were 11 people on the ward and one vacant bed.

We last visited this service in October 2024 on an announced basis and made recommendations on involving individuals and family/carers in developing care plans, documenting of multidisciplinary team review meetings, awareness and recording when formal proxy decision makers were in place and consulting them as required, providing accessible information on the locked door policy, and improvements relating to the garden fencing with respect to privacy.

A comprehensive action plan was received from the service for all recommendations, and we wanted to follow up on progress.

Who we met with

We met with seven individuals and reviewed the care records of four of these. Unfortunately, there were no family members or carers who requested to speak to us on the day of the visit.

We spoke with the senior charge nurse (SCN), the charge nurse, two staff nurses, a student nurse, and the occupational therapist (OT) for the ward. We spent time in two of the activity groups which took place on the ward.

Commission visitors

Audrey Graham, social work officer

Gordon McNelis, nursing officer

Graham Morgan, engagement and participation officer (lived experience)

What people told us and what we found

Overall, the individuals we met with were positive about the care and support they received in the ward. One person told us, “staff will do anything for you” and another said, “I don’t like being in places like this, but this is the best one I’ve been in”.

We heard that the ward was “a welcoming place”, was “friendly and fun” and “it’s a good atmosphere”. One individual told us that the ward was a “nurturing place to be”. Several people told us that there were lots of activities on the ward and “you never get bored”.

Individuals talked about regular one-to one support time and discussions with medical and nursing staff taking place. We heard that there was open dialogue and a receptiveness to questioning. One individual said “the doctors explain to me what they want to do and I feel able to question them” and another said, “you can ask if you don’t think things are right” and “I have a say in the decisions about me”.

A culture of openness to alternative perspectives was a theme from discussions we had with staff. One said “it’s a ward where you can challenge and question and you’ll be listened to”; another said “there are often differences of opinion but it’s never a big deal”.

We heard about a supportive team culture with lots of team building activities. One staff member said, “the team here is like a family”.

We heard that learning and development of staff was valued and promoted. The SCN told us how staff were encouraged to bring ideas for improvement to the team and to work on their own improvement projects autonomously. This was evidenced by a staff nurse telling us about the creation of a sensory room in the ward that they had been instrumental in progressing; “I went ahead and got the grant. Our ideas are supported; we’re encouraged to use our strengths”.

Staff told us about opportunities for reflection and learning on the work that they do. We heard from a student nurse about a positive learning experience and a perception that “staff really want to share their knowledge and include me”.

We did hear some concerns from staff that their capacity to spend adequate time with individuals was impacted by the time it took to complete all the recording required. Some felt that there should be an exercise undertaken to streamline paperwork.

Care, treatment, support, and participation

We were told that in the last couple of years there had been an increase in admissions of individuals who had carried out serious self-harm or attempted to complete suicide. We heard from the SCN that previous significant adverse events had had a significant emotional impact on staff but had also prompted more reflection and learning.

We saw that recovery focused work was actively taking place on a group and one-to-one basis, led by a specialist recovery nurse and the OT. We thought that this work was to be commended.

While individuals' views were recorded through care records and individuals told us that they felt included and listened to, we thought that the inclusion of people at their weekly review meetings was an area that could be improved upon. One person told us "I don't think we're allowed to go to those meetings" and another said, "I don't know what's said at those meetings".

As well as hearing positive views overall from individuals on the care and support they received, we observed warm, respectful and humorous communication and interactions. It was apparent that staff knew the individuals on the ward well and experienced empathy relating to individuals' stories. The care and support provided was felt to be person-centred.

We witnessed a skilled approach to enabling individuals to participate in the recovery group and in the weaving group which both took place on the day of the visit. We observed these groups to be informative, inclusive and lively, with lots of humorous and positive conversations taking place.

Care records

We thought that the care records reviewed were person-centred, giving us a holistic picture of each individual. We saw full, informative, and regular reviews by psychiatrists relating to mental state, with detailed and clear reviews from other medical staff relating to physical health issues.

There was evidence of regular one-to-one time between individuals and their named nurses. Updates from OT were of a high standard, providing helpful analysis of individual functioning and progress.

We found the care plans to be person-centred, thorough, detailed and they provided practical, descriptive interventions that guided staff in the delivery of care, support and treatment. We saw that care plans were being reviewed regularly but reviews were brief and lacked analysis about what interventions were working. We could not see whether reviews always initiated the changes required in the body of the care plan.

It was good to see that individuals had a specific care plan on discharge, prompting a focus on necessary changes and tasks to be achieved to enable the individual to move on. There was evidence that some individuals were involved in developing their care plans, however three out of the seven people we spoke to said that they did not know about their care plans.

We heard that care plans were audited monthly by the ward charge nurses and that progress was tracked relating to recommendations we had made from previous visits, including involvement and participation of individuals and carers. We heard that analysis showed that steady improvement was being made. Charge nurses provided feedback to nursing staff using an agreed template to ensure consistency. We were pleased to see this prioritisation of improvement-focused audit activity.

There were risk assessments in place in each care record we reviewed. Overall, risk assessments were of a good standard overall but did not include risk management plans. Sections relating to individual strengths and formulation were not completed.

Recommendation 1:
Senior charge nurses should ensure that a clear risk management plan is completed for each individual and should consider incorporating reflection on individual strengths and psychological formulation, to enhance risk assessment and risk management planning.

Multidisciplinary team (MDT)
The SCN advised that there had been staffing challenges in the few weeks before our visit; this was due to the increase in winter flu-type bugs and two members of the nursing team were on long-term sickness absence. We were advised that the ward had access to bank staff who returned regularly and who knew the individuals on the ward well. We thought this was another positive indication of good leadership and culture.

We heard that medical cover was stretched, with one consultant psychiatrist in post half time, who also covered the liaison psychiatry service at Murray Royal Hospital (MRH). There was additional consultant cover of two half days. Both consultants attended one MDT review meeting each Wednesday afternoon to ensure that they had an awareness of everybody in the ward and could cross-cover.

We heard that in addition to the full MDT review meetings on a Wednesday, there was a briefer MDT meeting on a Friday, where decisions and plans could be made for the weekend. We thought that this was positive in terms of keeping care plans dynamic and supporting progress towards discharge.

We heard that there was regular input to the ward from OT which was well received, however the service was stretched due to having a vacancy. There was a good level

of input from dietetics, with a dietician based at MRH attending the ward twice a week.

We were told that physiotherapy could be accessed on a referral basis although used to be more present on the ward as part of the MDT. We were told that the waiting list for psychology input was around six weeks at times but that there was a reasonable level of input to the ward.

Podiatry was difficult to access, and we were advised that people often had to make private arrangements. This was a concern given the importance of the service for this older group of individuals and the possibility that some would be unable to afford to pay privately. We heard that dentistry services were available and straightforward to access via Kings Cross Community Hospital if individuals did not have their own dentist.

The recording of MDT review meetings was generally of a high standard in terms of summarising individual progress, with a range of professionals generally in attendance. We did not always see clear plans identified or who should take tasks forward from MDT meetings. As noted, at least two individuals we met with did not feel included in their MDT meetings.

Use of mental health and incapacity legislation

On the day of the visit, two out of 11 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). We found that all paperwork relating to these detentions was accessible and in order.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

We carried out a review of prescribed medication for individuals who were not subject to the Mental Health Act and found that one was prescribed an intra-muscular sedative medication as required to alleviate distress. The Commission has concerns about IM ‘as required’ medication being prescribed for people who are informal. This is because it is likely that they would not consent to receive the treatment if it was later administered.

We consider it best practice for a medical review to be arranged if circumstances arise where IM medication may be required. This was raised with medical staff on the day. We were advised that the individual had never been given this medication and that it would be discontinued on the prescription record.

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 (AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. One individual had a s47 certificate in place and this was completed in line with the requirements.

There were two individuals who had granted power of attorney (POA) in terms of the AWI Act. Neither of these POA's had been enacted and staff were clear on the status of the POA's. We thought that staff were knowledgeable and demonstrated awareness relating to the AWI Act, including the role of proxy decision makers.

Rights and restrictions

There was a clear policy covering access to and exit from the ward, which was shared with individuals on admission and was referred to in the ward information booklet.

While there was information for staff relating to review of the locked door status at the main door, there was no information for individuals. We would recommend that this is put in place in an accessible format. We did not hear from any individuals that they felt restricted by the door being locked.

We heard that staff had recently been trained on the 'Improving Observation Practice' guidance. A 'floor nurse' role had been put in place, which ensured that all individuals were seen at regular intervals. The floor nurse was stationed near the main door of the ward, but in an open area with comfortable seats where individuals could join them for a one-to-one chat. While the role offered increased capacity for monitoring of individuals, it was positive to see that it was carried out in an unobtrusive way.

The advocacy service covering the ward advised us that they felt welcome there and that staff valued the role and referred individuals as needed.

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 two advance statements in the records we viewed. We did hear that one individual was given medication when acutely distressed that was contrary to their advance statement. Staff had been unaware that the advance statement was in place and reassured us that the process for ensuring ward staff are aware would be

looked at. We discussed the obligation to notify the Commission of instances when advance statements are overridden.

We heard that the ward rarely had individuals who had advance statements in place and it seemed that until recently, little had been done to promote these. However, discussions had begun to consider what staff needed to learn about advance statements and how they could promote uptake.

Recommendation 2:
Senior managers should ensure that staff are familiar with their role in promoting the use of advance statements and providing individuals with information and assistance with this. These discussions should be clearly documented in the clinical records, along with a copy of any advance statement. Any instances where an advance statement is overridden should be notified to the Commission.

Activity and occupation

We were able to view a variety of activities taking place in the ward through the course of the day, from weaving and knitting, to curling and a recovery group. The recovery and activities staff members were highly valued by some of the individuals we met with.

There was an activities board clearly detailing what was on offer that day. There were ongoing arts and crafts projects on the walls of the unit. The importance of physical exercise and movement was promoted by pictures and simple instructions on display up and down the main corridor.

There was a 'Busy Board' offering ideas and resources including various types of puzzles, to stimulate thinking and engage individuals in meaningful occupation. We heard about a collaborative effort to make a blanket made up of many colourful squares, for use when individuals who needed wheelchairs were taken out.

We saw specific care plans relating to meaningful activity in individual care records as well as helpful summaries of what activities people had taken part in through the week. We observed that there was significant value placed on meaningful and therapeutic activities. We thought that staff were imaginative and committed to delivering activities and that this resulted in a stimulating and engaging atmosphere on the ward.

The physical environment

The ward environment was clean and comfortable and individual rooms were spacious and personalised, with each having their own television. As noted, there were arts and crafts projects and exercise programs covering the walls. There was lots of colour and much for people to engage with.

We thought that staff were doing all that they could to optimise the physical environment for people. We were pleased to hear about the ongoing work on setting up a sensory room.

The garden area was neat and tidy with some good quality seating. On our previous visits we recommended that the fence be replaced as it did not afford privacy. This had not been done but we were told that the service had been awarded a grant to improve the garden area which would include more appropriate fencing. We will therefore repeat our previous recommendation and would hope this work is undertaken as a priority.

Recommendation 3:
Senior managers must 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.

Summary of recommendations

Recommendation 1:
Senior charge nurses should ensure that a clear risk management plan is completed for each individual and should consider incorporating reflection on individual strengths and psychological formulation, to enhance risk assessment and risk management planning.

Recommendation 2:
Senior managers should ensure that staff are familiar with their role in promoting the use of advance statements and providing individuals with information and assistance with this. These discussions should be clearly documented in the clinical records, along with a copy of any advance statement. Any instances where an advance statement is overridden should be notified to the Commission.

Recommendation 3:
Senior managers must 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.

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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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