Mental Welfare Commission for Scotland

Report on announced visit to:

Kingsway Care Centre, Ward Three, King's Cross Road, Dundee, DD2 3PT

Date of visit: 25 September 2023

Where we visited

Ward 3 is based in the Kingsway Care Centre, Dundee. It provides assessment, care and treatment for mixed gender adults, predominantly over the age of 65 who have a diagnosis of dementia; on occasion, it will treat people under 65. The ward has 12 single rooms all with en-suite facilities, this is a reduction of five beds since the previous visit. On the day of our visit there was one vacant bed.

We last visited this service in June 2019 and made one recommendation in relation to the environment, specifically allowing for safe patient observation whilst patients were in their bedrooms. We heard that this work was partially complete and should be complete by the end of 2023.

On the day of this visit we wanted to follow up on this previous recommendation and hear how patients and staff managed throughout the pandemic, given that our last visit preceded this. We were also keen to look at the impact of any continuing subsequent adaptions or restrictions that may have been made.

Who we met with

We met with seven patients and reviewed the care notes of five patients. In addition to this, we met with two relatives and had a phone call with another.

Prior to the visit we had a video call meeting with both the senior charge nurse (SCN) and clinical nurse manager (CNM). We met with them again in person on the day of the visit and spoke with other clinical staff. The ward consultant psychiatrist and locality manager joined the post visit meeting for feedback.

Commission visitors

Denise McLellan, nursing officer

Tracey Ferguson, social work officer

Kathleen Liddell, social work officer

What people told us and what we found

Care, treatment, support and participation

We met with several patients during our visit but due to the level of cognitive impairment, we were unable to have any detailed conversations with them. However, they told us that they were well looked after and felt safe. We were able to observe activities they were engaged in, as well as interactions between staff and patients. We acknowledged this as being positive, warm, caring and respectful. Staff that we spoke with knew the patient group well. We were pleased to see that efforts had been made to support individuals with their personal care, encouraging them to wear items that were of significance to them, such as a favourite piece of jewellery. One relative commented that they had always found this to be the case including when visits were unplanned and told us that "care is immaculate", "I have peace of mind, and they always make the time".

Overall, feedback from families was positive however, one relative informed us that they felt communication with ward staff was limited. They told us they were not invited to weekly ward meetings however, were now contacted by the responsible medical officer (RMO) weekly after these meetings; they could speak by nursing staff out with this if any issues arose. We discussed this with the SCN who told us that the multidisciplinary team (MDT) will continue to work with families to improve the level of communication. Other relatives provided feedback about high standards of care and feeling that they were listened to.

Ward 3 had experienced significant staffing challenges, including registered nurse vacancies. The SCN told us about the impact Covid-19 had on retention of staff and shortages from sickness absence. We heard that there had been increased stress on the staffing group following a period where there had been some extremely challenging behaviour that resulted in significant levels of staff injury. Although the situation was improving, it had been exacerbated by the existing shortages. Efforts were being made to address staffing locally. Two newly qualified nurses had recently been recruited, with further recruitment ongoing.

Multidisciplinary team (MDT)

The ward had an MDT on site consisting of a nursing team, medical staff, ward-based activity support worker, psychiatrist and part-time occupational therapist, as well as colleagues from pharmacy, social work and physiotherapy. In person MDT meetings took place weekly on the ward. The ward also had access to an advanced nurse practitioner (ANP). Referrals were made to other services as and when required.

It was unclear from the otherwise detailed MDT meeting notes whether everyone involved in an individual's care and treatment was invited to attend and provide an update on their views or who was responsible for action points, for example, reporting back to families or carers. It was also unclear to see 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. It would be good to see more participation and more active advocacy involvement.

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

Care records
Information on patients care and treatment was held on the electronic record system EMIS. In addition to this, individual care plans were held in paper format. This enabled staff without access to EMIS to have timely access to specific information about patients.

We found detailed, person-centred care plans that were strengths-based and included protective factors. They addressed a wide range of care for mental health, physical health, and the more general health and wellbeing of the individual. The care record contained 'Getting to know me' documentation, evidencing family/carer involvement, that promoted opportunities for individuals' wishes and preferences to be realised, in conjunction with helping to inform care planning. Dementia UK 'My life story' was also completed and the named nurse system was in place. The recording of one-to-one conversations between patients and staff was variable, with some records only giving minimal information.

We saw evidence that physical health care needs were being monitored and addressed. In addition to regular medical provision, the ward also had access to an ANP, who was a registered general nurse. The ANP attended multidisciplinary meetings when required.

The care plans were very detailed and reviewed regularly. While we found the nursing care plans to be of a high standard, the link between the care plans and the daily recordings on EMIS, which were brief, was not always clear. Regular audits were being completed, so it was suggested that this could be added to the audit to encourage more qualitative information in the daily consultations. The 'Five Pillars' model of formulation was being used to inform comprehensive risk assessment and management. One risk assessment was missing from the paper file, but we were informed that this had been completed but may not have been printed off. We were told of plans to transition to an alternative electronic system (MORSE) in the future, and it was expected that this would provide an improvement in the recording of, and easier access to information.

One patient was awaiting a move to a care home however their discharge was delayed, pending the guardianship process being completed. We explored this further following the visit and were reassured that the appropriate measures were being put in place to support the move.

Use of mental health and incapacity legislation

On the day of our visit three patients were detained under compulsory measures in accordance with the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act). Relevant detention paperwork was available and certificates authorising treatment (T3s) were in place with medication appropriately authorised. There were paper copies of medication prescription kardexes and T3 certificates that were easy to locate. We were told that Ward 3 was involved in a 'safe wards' quality improvement initiative, which aimed to identify and reduce the use of 'as required' medication administration.

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 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. We found that documentation pertaining to the AWI Act, including certificates around capacity to consent to treatment were in place in most of the paper files we looked at and were up to date, however, we found that the section 47 treatment plans were not completed in accordance with the code of practice for medical practitioners; they were not personalised or detailed in relation to individual needs.

We were told that AWI Act training had been delivered to nursing staff by a mental health officer during the previous week. Training is also available on the TURAS platform which is recorded, so that this can be available to staff irrespective of their work pattern. We were unable to locate a copy of a welfare guardianship order, or the specific powers granted for one patient. This was highlighted to the SCN who will follow this up.

Recommendation 2:
Further training should be delivered to medical practitioners in completion of section 47 treatment plans in accordance with Adults with Incapacity (Scotland) Act 2000 code of practice.

Rights and restrictions

Ward 3 continued to operate a locked door, commensurate with the level of risk identified with the patients as a group. Individual room doors were locked, however nursing staff said patients can have access to the rooms on request. We were told that the decision to lock the doors was taken after consultation with relatives and carers, following incidences of personal belongings being removed from rooms. Both policies were displayed on the noticeboard in the ward corridor.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. One patient was a specified person in relation to restrictions on telephone use. The relevant specified person documentation was on file along with a reasoned opinion, detailing the requirement of the restriction and there was evidence of regular review.

The term 'advance statement' refers to written statements made under s274 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. Although patients in Ward 3 were unable to write their own advance statement, they should be supported to participate in decision-making. There was evidence of referrals to advocacy being made within the notes in order to support this process.

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

their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

In addition to one part time occupational therapist, Ward 3 had recently appointed an activity support worker. One of the rooms was used for dedicated activity and there was another quieter lounge for patients. The ward had shared access to transport for community interest visits but could also use private taxis to facilitate activities. It was clear from our observation on the day that activities were taking place, but these were not always being recorded in detail. Where activities were offered, but declined, this should also be documented. We saw patients participating in card games and nail painting and they told us that this was something that they enjoyed. There was good care planning around activities, but it was unclear how this translated in the day-to-day participation on the ward.

The physical environment

The ward environment was clean, with a calm and relaxed atmosphere. A few patients were noted to be sleeping for long periods. We discussed this with staff and were told that for one patient this was a recent change in his presentation.

The layout of the ward consisted of 12 single rooms. There was a lounge area, a separate dining room for the patients and an activity lounge. All were brightly decorated and spacious. The environment was spotlessly clean and we were able to see the efforts made to soften the public rooms with an adapted fireplace in one of the lounges. We were told that this room was decorated in accordance with the seasons, for example, a Christmas tree with baubles and lights. Some paintings were still to be re-hung as there had been consideration given to replacing some artwork to reflect the differences in changing age group and interests. We particularly liked the flower border decal applied along the bottom of the corridor wall. This served a dual purpose. As well as being pleasant and cheerful to look at, it was also useful in creating a visual demarcation between the floor and wall, thus assisting patient orientation around the ward aiming to reduce the likelihood of falls.

The dormitory areas were less personalised for the patients. Although there were personalised boxes outside each room, they were mostly empty. There was evidence of personal items including photographs in each bedroom that we viewed. We noted minimal signage on walls and were told that this was regularly removed by patients. Information about access to spiritual care was provided on the noticeboard and we were told by staff that this was a drop-in service but that this could also be arranged on an ad hoc basis by patient request.

Families could visit their relatives on the ward or in the café close to the entrance. Weather permitting, they also had access to the garden. During Covid-19 when some restrictions were eased, families were encouraged to visit their relative in their own room. This was found to be beneficial, both for infection control and increasing dignity and respect to other patients who were accessing the main areas of the ward. It was also felt to be helpful for children who were visiting relatives. This practice had continued and there were no plans to change it. Each bedroom had French doors opening directly onto the garden.

Visitors were able gain access by phoning the ward or alerting nursing staff at the main door of the ward on arrival.

The ward garden was adjacent to a busy main road and was not private. This area had bamboo fencing in some areas, however due to weathering, sections of the fencing was missing and the privacy and dignity of patients and relatives was compromised. We were told by the SCN of efforts to secure funding to develop a sensory garden in this space. To date, all attempts had been unsuccessful, due to the building being used by NHS provider.

Recommendation 3:
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 patients and relatives who choose to use this therapeutic space.

Any other comments

We were told about plans to develop a digital padlet which would include videos of the ward as part of a quality improvement initiative to increase family/carer information. We were told this idea had been borrowed from practice elsewhere. Attempts to establish a specific carers group had been unsuccessful, however useful links had been made with general adult services that carers could access. We were told that the ward had adopted the 'Triangle of Care' approach to increase participation between, families, patients and the care provider.

It was evidently clear that the SCN was invested in the ward and staff. Although some difficulties with staff retention were acknowledged, things appeared to be improving. The development of a 'relax and recharge' room was made available for staff during the pandemic in recognition of demands on them. This resource will continue to be available for use, cognisant with needs of providing care in this demanding care environment.

Summary of recommendations

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

Recommendation 2:
Further training should be delivered to medical practitioners in completion of section 47 treatment plans in accordance with Adults with Incapacity (Scotland) Act 2000 code of practice.

Recommendation 3:
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 patients and relatives who choose to use this therapeutic space.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report.

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 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

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk