Mental Welfare Commission for Scotland

Report on unannounced visit to:

Ward 4, Kingsway Care Centre, Kingscross Road, Dundee, DD2 3PT

Date of visit: 19 June 2023

Where we visited

Kingsway Care Centre is an old age psychiatry facility in Dundee. In this facility, Ward 4 is a 14-bedded admission / assessment ward for both male and female patients with a functional mental illness. On the day of our visit, the ward was at full capacity, with seven males and seven female patients in the ward.

The Commission last visited Ward 4 in June 2019 as part of a national themed visit which focused on older people's functional mental health wards in hospitals. Although the themed visit was not part of the Commission's local visit programme, we were able to identify areas of good practice and no recommendations were made at the time. The Commission's last local visit to Ward 4 took place in April 2018, when a recommendation was made to ensure bedrooms had facilities to allow for safe patient observation without staff having to enter bedrooms. In addition to this, and although not a recommendation, the Commission suggested that the garden area be developed.

In response to the recommendation, we were pleased to find that observation doors were in place at the entrance to all patient rooms. In further discussion with staff, we were pleased to note that there was a focus on not disturbing patients during routine checks and respecting their need for privacy.

We were also pleased to see the garden area had been developed into a well-maintained, open space, with plentiful planting that resulted in a therapeutic environment for patients to enjoy. However, the garden area was enclosed by wire metal fencing which gave no privacy to patients accessing the garden when passers-by were entering or leaving the hospital car park.

This was an unannounced visit, and due to this there was no contact with relatives on the day. We asked ward staff to give our contact details to any relatives who might wish to speak with any of the Commission visitors after our visit, to discuss any aspects of their relatives' care or treatment.

Who we met with

We met with four patients and reviewed their notes.

We spoke with the service manager, associate locality manager, associate medical director, charge nurse, staff nurse, nursing assistant, occupational therapist, activity nurse, and student nurse.

Commission visitors

Gordon McNelis, nursing officer

Lesley Paterson, senior manager (practitioners)

What people told us and what we found

Care, treatment, support, and participation

On the day of our visit, we wanted to meet with as many patients as possible to discuss their views on the care and treatment they received. Although this was an unannounced visit and there was a pre-arranged group outing to the community on the day, we were able to meet with four patients who were willing to discuss their care and treatment. In our contact with patients, the overall feedback was positive. Patients told us that the staff were 'approachable', and 'nice', that they were treated very well, and had contact with their responsible medical officer (RMO) most weeks.

Care Plans

We reviewed care plans and found that there was good awareness of individual needs and descriptive interventions of what had been delivered. The content was thorough and descriptive, with wording that a reader from a non-clinical background (patient, family member, carer) could easily understand. A common focus throughout care plans, which included physical health care monitoring and activities of daily living, was promoting and maximising independence. We were pleased to find that this theme was evident when speaking to all staff disciplines. There was also an ethos of providing the least restrictive care while focusing on patients' existing abilities.

Pharmacy staff also contributed to the care plans in the case notes. These records provided information of current and historical issues and provided the reader with a clear explanation and direction of pharmacological treatment. There was evidence of regular monitoring and reviews by staff however, we found there to be a lack of patient, family, and carer involvement in care plans. We believe their input and participation would make care plans more person-centred and relevant; overall the care plans we reviewed were of a good standard. We noticed a communications board in the main corridor that had the outcomes of a recent care plan audit, displayed for patients and visitors to the ward to see. We were advised that this is updated after each audit.

We found that the risk assessments focused on identified risks, including risk of self-harm.

The Commission has published a good practice guide on care plans. 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, and can be found at:
https://www.mwcscot.org.uk/node/1203

Multidisciplinary team (MDT)

Ward 4 had a multidisciplinary team who were available and visible to patients in the ward. The relationship between staff and patients was noted to be supportive. The team consisted of mental health nurses, medical staff, an occupational therapist, an activity nurse, nursing assistants, and domestic staff. We were made aware of some staff absences and also unfilled vacancies on the ward, however some vacancies were expected to be filled in the near future. On the day of our visit, we heard that reduced staffing could affect staff morale, but on a positive note, there was a core group of experienced staff who remained committed to delivering person-centred care. We were informed that although registered mental health

nurses (RMN) who were employed as bank nurses were routinely used, there was an effort to use a core group of bank staff, which provided continuity, as they were familiar with the patients and ward.

MDT meetings were well documented and noted to have a good level of attendance from the range of professionals who provided care, treatment, and support to Ward 4 patients. We were told a nominated social worker and community psychiatric nurse (CPN) regularly attended MDT meetings to keep updated of known patients. Ward staff also regularly liaised with CPNs to ensure there was input from the Community Mental Health Team (CMHT) for those patients who were preparing for discharge into the community. The discharge team attended the ward on a weekly basis to be made aware of potential transfers or discharges. We felt this level of ongoing communication, along with the involvement of community colleagues supporting the preparation for discharge planning, was good practice.

MDT meeting notes showed continuity and progress of treatment plans from the previous MDT meeting. We found them to be detailed and they recorded observations of the patient's mental state, any issues, and concerns, as well as a description of the individual's general presentation. However, we noted that there was no input from patients, family, or carers and we felt that it important for their views be included in MDT discussions.

Recommendation 1:
Managers should ensure that patients, relatives, and carers are involved in all aspects of care and treatment, including care planning and input to MDT meetings with clearly established and agreed lines of communication.

Care records

Information on patients' care and treatment was held on the electronic record system, EMIS. We found that information such as patient assessment, care plans, MDT notes, and risk assessments were easy to locate, well organised, and regularly updated and reviewed. Maintaining and promoting the patient's independence was a common focus throughout the routine entries however, terms, such as 'settled' or 'kept a low profile' that were frequently documented in the records lacked the detailed clinical description of an individual's mental state that we would have hoped to review. Health professionals should provide a clear descriptive account when recording clinical information, to give a comprehensive account of whether a patient's mental health is showing signs of improvement or deterioration. We raised this with senior staff on the day of our visit. We also observed individual patient information documented on a wipe board in the duty room. This information included a record of whether cardiopulmonary resuscitation (CPR) was to be attempted in the event of a patient's physical deterioration. We were told by staff that this key information was discussed and reviewed at each shift handover, however, we highlighted that clinical information such as this should be stored safely and confidentially.

Use of mental health and incapacity legislation

On the day of our visit, three of the 14 patients in Ward 4 were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). During our review of patient's case notes, all detention documentation relating to the Mental Health Act was in place.

The patients we met with during our visit had a reasonable understanding of their detained status however, we believed individuals would benefit from accessible information regarding their status under the Mental Health Act.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Only one patient in the ward was required to have a certificate authorising treatment (T3) under the Mental Health Act. Unfortunately, this was not in place on the day of the visit, and no member of staff could locate it for us. We followed this up after the visit and the certificate had been completed but was not available in the ward during our visit.

Recommendation 2:
Managers should ensure that there is a system which identifies that all patients who require a T2 or T3 certificates have these in place and ensure that the certificate corresponds to all prescribed psychotropic medication and that a copy is to be held with the medication kardex.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file.

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 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. Where these were required, we found s47 certificates had been completed and there was an associated treatment plan.

Rights and restrictions

A locked door policy remains in place at Ward 4 to provide a safe environment and support the personal safety of the patients. We were made aware of staff facilitating escorted outings for patients around the hospital grounds and in the local area.

During our last visit to Ward 4, we noted there was good advocacy input to the ward, and that advocates would attend MDT meetings when a patient wished this support. However, we found that this level of input from advocacy was not as consistent as previously noted and we identified that there were patients who could have benefitted from advocacy involvement. We raised this with staff on the day and were assured that referrals would be made for not only these patients, but for all who wished to access advocacy services.

S281 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 these sections of the Mental Health Act, and where restrictions are introduced, it is important

that the principle of least restriction is applied. The RMO must, prior to any restriction being implemented, have recorded a reasoned opinion that states why without restrictions being in place, there would be a risk to the individual or to others. On the day of our visit, only one patient was subject to specified person legislation, however, there was no reasoned opinion in place. We discussed this with managers on the day of the visit and were told this would be addressed.

Our specified persons good practice guidance is available on our website.

http://www.mwcscot.org.uk/media/216057/specified_persons_guidance_2015.pdf

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

Ward 4 had both a dedicated occupational therapist and an activity nurse who provided a good level of daily activity, structure, and routine for patients to participate in. We met with both and also observed them preparing the activities for the day ahead. Both were enthusiastic and keen to tell us about their role and the person-centred, recovery focused activities that were offered to patients. These included group sessions that focused on mindfulness, anxiety management, and behavioural activation training, which encouraged patients to engage in positive and enjoyable activities to enhance their mood. This was widely used in the ward, with a series of sessions taking place twice per week. We also observed the preparation of a recovery group led by the ward-based occupational therapist and co-facilitated by a student nurse. The purpose of this group was for patients to identify activities they enjoyed, and that helped them in their recovery. This information was then used to formulate person-centred treatment plans.

Activities were planned in advance and this information was readily available for patients to view on an information board in the main corridor of the ward. We were told there was also focus on physical movement and exercise in the ward which could be varied, depending on the individual patient's capabilities. In addition to this, staff facilitated escorted walking groups in the local area, and attendance at a local community centre, where patients were given free access to use the facilities. One of the patients we spoke with mentioned that they valued the escorted time out of the ward and also the graded exposure visits to their home with staff, which meant that they felt more confident taking part in outings to local shops, attending appointments, and also had support with the prospect of their pending discharge home. Some patients mentioned that they would appreciate more activities to be made available at the weekend. We raised this point with staff and were told the programme of activities would be reviewed. We were pleased to hear about the follow up work that the inpatient occupational therapy staff have with their community based colleagues, in order to make them aware of the patients' level of ability. This included a daily maintenance plan that was formulated for the community setting, which aimed to highlight, maintain, and promote existing skills and independence.

The physical environment

Ward 4 is a 14-bedded unit comprising of individual bedrooms, each with en-suite facilities. On our previous visit, we made a recommendation regarding a potential safety risk with staff being unable to easily observe patients in their rooms, without entering the room. We were therefore pleased to see all doors to the patients' bedrooms had been replaced with doors with switchable glass windows that enabled observation of the patient and room, whilst also promoting privacy.

Ward 4 has a designated area that is reserved for occupational therapy and activity nurse groups to take place. This room had windows looking out to the garden, which had a good source of natural sunlight; we found this area fitting for therapeutic activity to take place. This room had access to the garden area which was well maintained and in keeping with the therapeutic surroundings. We heard that the time patients spent in the garden provided them with not only structure and purpose, but also this appeared to offer them a quality of life aspect to their day. This part of Ward 4 evidently provided patients with an enjoyable place to be, although we did find that this area had no privacy from an adjacent footpath that led to the hospital car park. We felt that the wired metal fence that separated the garden from the external path, was not only cage-like but also provided no privacy for patients and detracted from the therapeutic feel of this area. Whilst on the ward, we observed a number of ligature points in patient bedrooms and en-suite areas. This was raised and discussed with managers during our feedback meeting, where we were informed of planned additional redevelopment to patients' bedrooms across Kingsway Care Centre. We heard that in the next phase of works, which included ongoing ligature assessment, there was a plan to renovate two existing bedrooms into anti-ligature rooms, for any patients who were assessed as being at risk to themselves. We were informed work was underway to gather information and intelligence from other NHS services on how best to ensure anti-ligature rooms were developed for this particular patient group.

Recommendation 3:
Managers should ensure the garden areas existing fencing is altered to provide privacy for patients using the garden and one which fits with this natural environment. It had been raised as a recommendation to install fencing that provides privacy and is fitting with this natural environment.

Recommendation 4:
Managers should produce and progress a programme of anti-ligature work, with identified timescales to address the identified ligature risk in the ward.

Summary of recommendations

Recommendation 1:
Managers should ensure that patients, relatives, and carers are involved in all aspects of care and treatment, including care planning and input to MDT meetings with clearly established and agreed lines of communication.

Recommendation 2:
Managers should ensure that there is a system which identifies that all patients who require a T2 or T3 certificates have these in place and ensure that the certificate corresponds to all prescribed psychotropic medication and that a copy is to be held with the medication kardex.

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Recommendation 4:
Managers should produce and progress a programme of anti-ligature work, with identified timescales to address the identified ligature risk in the ward.

Service response to recommendations

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

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