Report of the Inspector of Mental Health Services 2012

EXECUTIVE CATCHMENT AREA/INTEGRATED SERVICE AREA	Independent Hospital
HSE AREA	Independent Hospital
MENTAL HEALTH SERVICE	Independent Hospital
APPROVED CENTRE	Bloomfield Care Centre
NUMBER OF WARDS	4
NAMES OF UNITS OR WARDS INSPECTED	Donnybrook Owendoher Kylemore Swanbrook
TOTAL NUMBER OF BEDS	112
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	14 February 2012

Summary

- Bloomfield provided care and treatment in an excellent environment.
- Individual care plans were not provided for each resident.
- The key worker system was not operating in any meaningful way in relation to individual care planning.
- The service user voice was not adequately supported or captured except in relation to the making of complaints. Service users were not provided with adequate written information in relation to diagnosis and treatments.
- There were excellent recreational programmes in place, however the provision and specification of therapeutic interventions was inadequate in relation to assessed need. The range and number of health and social care professionals was inadequate.
- A clinical governance committee had been established.

OVERVIEW

In 2012, the Inspectorate inspected this Approved Centre against all of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The Inspectorate was keen to highlight improvements and initiatives carried out in the past year and track progress on the implementation of recommendations made in 2011. In addition to the core inspection process information was also gathered from self-assessments, service user interviews, staff interviews and photographic evidence collected on the day of the inspection.

DESCRIPTION

Bloomfield Care Centre was located in the Dublin foothills amidst landscaped gardens and had an attractive outlook for residents. The 112-bed approved centre was located within the Bloomfield complex, and comprised four wards, namely, Owendoher, a high dependency ward, Donnybrook, a medium dependency ward and Kylemore and Swanbrook, both rehabilitation wards. Residents were mainly elderly with functional mental illness, early onset dementia and acquired brain injury. A small number of residents were in the 40s to 50s age bracket. Accommodation was spacious, generally in single rooms and the units were laid out around court-yards, with downstairs units having direct access to the outdoor areas. Units were locked. Admissions were planned and referrals were accepted from other mental health services. On the day of inspection there were six detained patients in the approved centre.

SUMMARY OF COMPLIANCE WITH MENTAL HEALTH ACT 2001 (APPROVED CENTRES) REGULATIONS 2006

COMPLIANCE RATING	2010	2011	2012
Fully Compliant	24	26	21
Substantial Compliance	3	2	5
Minimal Compliance	2	0	2
Not Compliant	1	2	2
Not Applicable	1	1	1

PART ONE: QUALITY OF CARE AND TREATMENT SECTION 51 (1)(b)(i) MENTAL HEALTH ACT 2001

DETAILS OF WARDS IN THE APPROVED CENTRE

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Donnybrook	37	30	Psychiatry of Old Age General Adult
Owendoher	24	13	Psychiatry of Old Age General Adult
Swanbrook	24	16	Psychiatry of Old Age General Adult
Kylemore	28	28	Psychiatry of Old Age General Adult

QUALITY INITIATIVES 2011/2012

- A clinical governance committee had been established.
- Consultant psychiatrist cover was now provided five days per week.
- A general practitioner attended five days per week.
- A review of services and programme format was underway.
- A “Bloomfield Olympics” physical activity fun-day had taken place.
- Healthcare assistant staff had all undertaken a Care of the Elderly FETAC Level Five course.
- Training had been completed in the care and management of individuals with an intellectual disability and mental illness.

PROGRESS ON RECOMMENDATIONS IN THE 2011 APPROVED CENTRE REPORT

1. All residents must have an individual care plan as defined in the Regulations.

Outcome: Not all residents had an individual care plan; however, there had been significant improvement in developing individual care plans.

2. Staff training in relation to physical restraint must be provided by the approved centre.

Outcome: This had not been implemented for all staff. Two staff had been trained as trainers and were due to commence in-house training.

3. The approved centre must have a Risk Management Policy that is compliant with Article 32 of the Regulations.

Outcome: The risk management policy met the requirements of the Regulations.

4. The approved centre should be compliant with the relevant Codes of Practice.

Outcome: The approved centre was not fully compliant with the Code of Practice on Admission,Transfer and Discharge to and from an Approved Centre, and the Code of Practice on the Use of Physical Restraint or on the Code of Practice: Guidance for Persons working in Mental health with People with Intellectual Disabilities.

5. Each psychiatric assessment of residents on admission should include a risk assessment and this should be reviewed regularly. Consideration should be given to introducing an admission form which includes physical assessment, full psychiatric assessment and risk assessment.

Outcome: The admission process included a risk assessment. The risk management plan might be more adequately elucidated.

6. Copies of transfer letters should be maintained in the resident's clinical file.

Outcome: Whilst there had been a significant improvement, not all individual files inspected contained the relevant medical record of correspondence.

PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE, AND SECTION 60, MHA 2001

2.2 EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)

Article 4: Identification of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Residents were identified by photograph on the drug kardex. Consent was obtained for taking a photograph. Medication was administered by one registered nurse.

Article 5: Food and Nutrition

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Food was prepared on site. A choice of meal was offered to residents and particular diets were catered for. There was access to fresh drinking water. Residents could avail of meals in the canteen in preference to eating in the ward if they wished.

Article 6 (1-2): Food Safety

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The most recent environmental health officer's report of the 30 October 2011 was available and the recommendations therein had been implemented.

Article 7: Clothing

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

All residents used their own clothes which were labelled and no resident was wearing night clothes. Laundry was done on site.

Article 8: Residents' Personal Property and Possessions

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The policy on residents' personal property was out-of-date and had been due for review in 2011.

A list of property was kept in the resident's clinical file.

Owendoher: There was no safe in the ward but valuables could be kept in the locked drug cupboard if necessary.

Kylemore: All wardrobes could be locked and there was secure storage for valuables.

Swanbrook: Valuables were locked in a safe in the nurse's office. Residents' money was kept in individual envelopes in a locked cabinet.

Donnybrook: All valuables and money were locked in a safe in the nurse's office.

Breach: 8

Article 9: Recreational Activities

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Newspapers were delivered to the wards on six days per week. Residents had access to TV/DVDs. Activities such as knitting and art were carried out in the wards. A movie night was held regularly in Owendoher ward and residents could attend a music night in Donnybrook ward twice weekly. An "Extend" class, a gentle exercise routine, was held weekly in Kylemore. The occupational therapist liaised with the activity coordinator to plan and deliver a recreational programme. The activity coordinator had won the Nursing Homes Ireland activity coordinator of the year award in 2011. Bloomfield had a mini-bus and six staff were licensed to drive, however, staff reported that outings were not provided on a regular basis.

Article 10: Religion

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The Society of Friends and the Jewish faith had particular input. A chaplain attended the wards weekly and Mass was held each week in Kylemore ward. One resident had recently begun attending Mass in the local church accompanied by a member of staff. Residents of other faiths were also catered for.

Article 11 (1-6): Visits

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The approved centre operated a flexible approach to visiting and visitors were welcome at most times. Visitors could visit in the residents' rooms or avail of a visitors' room. Children could visit if accompanied by a family member. There was a policy on visits.

Article 12 (1-4): Communication

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Owendoher: There was no public phone in the ward. Most residents did not have a mobile phone but could access the office mobile handset. Mail was delivered to the ward daily.

Kylemore: There was a handset phone which residents could use to make and receive telephone calls. Residents could retain their own mobile phone. Mail was delivered daily and post was unopened.

Swanbrook: Residents could use mobile phones if they wished. Residents' post was unopened by staff.

There was a policy on communication.

Article 13: Searches

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a policy on the carrying out of searches, with and without consent and on the finding of illicit substances.

Owendoher: Intermittent room searches had been carried out and residents were informed of the practice.

Kylemore: No personal searches had been carried out. One room search had been carried out with consent.

Swanbrook: No searches had been carried out.

Donnybrook: No searches had been carried out.

Breach: 13. 1

Article 14 (1-5): Care of the Dying

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a policy on the care of residents who are dying. Residents who were dying were facilitated in a single room. Arrangements were made for the palliative team to attend the resident when indicated. Relatives were facilitated with accommodation if necessary.

Article 15: Individual Care Plan

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*			
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*	X	X	X

Justification for this rating:

The registered proprietor had not ensured that each resident had an individual care plan. Whilst there were individual care plans in place for almost all residents, they did not meet the required standard as defined in Part 1 of the Regulations.

Owendoher: In three of four clinical files inspected, residents had an individual care plan. None of the care plans were signed by the resident and there was little evidence of the resident's involvement in their care plan; however, at least one of these residents was noted to be unable to indicate their involvement. One of the care plans specified an unmet need for psychology resources.

Donnybrook: Five clinical files were inspected in this ward. All residents whose clinical file was seen had an individual care plan. At least two residents were noted to be unable to sign. Multidisciplinary input into the care plan was recorded but in some cases, this consisted of medical and nursing input.

Kylemore: Five individual clinical files were inspected and all contained individual care plans (ICPs). There was no evidence that any of the residents had been actively involved in their own individual care plan process. The ICP proforma provided for the signature of a resident but this was left blank. A named key worker was identified for each resident. Inspection of individual clinical files indicated that the key worker role was not operational in relation to ICPs. The scope of the ICPs was disappointing, in that the documentation was largely confined to medical and nursing care and with the exception of the occupational therapy records, did not convey a sense of a holistic human being with a sense of a future. In many instances, occupation, personal preferences and values, and psychosocial history were not completed in the clinical documentation. The clinical records inspected did contain records of family meetings, but the focus appeared to be on acquiring a collateral history. The ICPs did not evidence family involvement in the process.

Swanbrook: Five clinical file were inspected. Four of these had ICPs. There was no evidence that the resident was involved in their ICP.

Breach: 15

Article 16: Therapeutic Services and Programmes

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*			
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*	X		
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*		X	X

Justification for this rating:

Each resident did not have access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan. The specification of therapeutic interventions in the ICPs was limited in scope and largely confined to medical and nursing domains of care. The elucidation of psychosocial needs and interventions in the ICPs did not ensure the provision of therapeutic services which restored or maintained optimal physical and psychosocial functioning.

Residents had access to medical, nursing and occupational therapy services. The occupational therapy records of assessment and intervention were excellent and embodied a recovery ethos. There was no social work or clinical psychology services. There was no evidence of talking therapies. Overall, the provision of therapeutic services was more akin to a nursing home than a modern mental health facility.

Additional services such as dietician, and clinical speech and language were available in a near-by general hospital if required, but there was often a delay in accessing these.

Breach: 16. (1), (2)

Article 17: Children's Education

Children were not admitted to this approved centre.

Article 18: Transfer of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The approved centre used a transfer form to document details of a resident being transferred. A member of staff accompanied a resident on transfer. There was an up-to-date policy and procedures in place in relation to the transfer of a resident.

Article 19 (1-2): General Health

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*		X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*	X		
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The general practitioner carried out routine six- monthly physical examinations and results of these examinations were kept in an electronic record. This information was not necessarily recorded in the individual clinical file, and whilst this is not a requirement under the Regulations, it was the view of the inspectors that it would be good practice to contain a record in the individual clinical file. Residents had access to national screening programmes. The approved centre had a policy on responding to medical emergencies.

Article 20 (1-2): Provision of Information to Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*			
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*	X	X	
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			X
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was an information booklet with general information relating to the Bloomfield Care Centre. There were leaflets from the Alzheimer's Association and Shine available on the wards, however, the approved centre did not meet its obligation to provide written information relevant to the resident's diagnosis and medication in an understandable form and language. There was no user-friendly written information on the range of diagnoses or medications relevant to the residents. There was written information on advocacy. The approved centre had a policy on the provision of information to residents.

An independent advocate visited the approved centre once a month.

Breach: 20 (1) (c) (e)

Article 21: Privacy

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Owendoher: Most of the accommodation was in single rooms and provided excellent privacy for residents. There were no partition curtains around two beds in one four-bed room, and in the three-bed room, one bed had no curtain.

Kylemore: Privacy was afforded in all bedrooms.

Swanbrook: Where bedrooms were shared there were curtains around each bed.

Donneybrook: There were curtains around each bed in each shared bedroom.

Breach: 21

Article 22: Premises

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The premises were in very good condition and provided spacious and bright facilities. The approved centre was clean and there was access to gardens.

Article 23 (1-2): Ordering, Prescribing, Storing and Administration of Medicines

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The policies relating to the administration, ordering and storing of medications were out of date. The policy on the prescribing of medication was up to date. Medications were sourced from a city pharmacist and delivered directly to each ward. There was no pharmacist on site. The approved centre subsequently advised that policies in relation to medication were currently under review.

Breach: 23(1)

Article 24 (1-2): Health and Safety

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a policy on health and safety and all wards had a health and safety statement in situ. The fire inspector's report of the 20 May 2009 was available and staff reported that all recommendations had been carried out.

Article 25: Use of Closed Circuit Television (CCTV)

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

CCTV cameras operated in the corridors of the ward and were for security purposes only. There was a policy in relation to this. There was signage for CCTV.

Article 26: Staffing

WARD OR UNIT	STAFF TYPE	DAY	NIGHT
Owendoher	CNM2	1	0
	Staff Nurse	2	1
	Health Care Assistants	4	2
Kylemore	CNM2	1	0
	Staff Nurses	2	1
	Health Care Assistants	4	2
Swanbrook	CNM2		
	Staff nurses	1	0
	Health Care Assistants	2	1
		3	1
Donneybrook	CNM2	1	0
	Staff nurses	2	1
	Health Care Assistants	4.5	2

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Registered General Nurse (RGN), Non Consultant Hospital Doctor (NCHD),Director of Nursing, (DON), Assistant Director of Nursing (ADON), Health Care Assistant (HCA)..

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*			
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*	X	X	
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still*			X

	needed.			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The staff skill mix was not appropriate to the assessed needs of residents, the size and layout of the approved centre.

There was a mix of registered general nurses and registered psychiatric nurses. There were two occupational therapists (OTs) on the day of inspection and staff reported that an additional OT was being recruited. The OTs provided services for the 112-bedded approved centre and the nursing home. Two consultant psychiatrists provided shared care for residents and provided cover five days per week. A general practitioner attended four days per week. There was no social worker or clinical psychologist. Access to social work was reported to be available via the resident's original mental health service and there was no record of social work input in the individual clinical files inspected. Access to a dietician and clinical speech and language therapy was on referral to a general hospital and staff reported long delays in getting an appointment. An activities coordinator provided recreational activities.

There were written policies and procedures in relation to staff recruitment.

The person in charge at night-time was an on-call CNM2. At night-tme the onsite staff in charge of each ward comprised staff grade nursing staff.

The physiotherapist provided input to the approved centre as required.

Breach: 26 (2)

Article 27: Maintenance of Records

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*		X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*	X		
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a policy in relation to records. The individual clinical files were maintained in good order. Documentation of food safety, fire inspection, health and safety were all available for inspection.

Article 28: Register of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The register was inspected and maintained in good order and up to date, however, the PPS numbers for residents were left blank in all instances. Where this was unavailable, the record did not indicate this.

Breach: 28 (2)

Article 29: Operating policies and procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The policies on the ordering and storing of medication, on residents' personal property, on the carrying out of searches, were out of date.

Breach: 29

Article 30: Mental Health Tribunals

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Mental health tribunals were held in the adjoining day centre and staff accompanied the residents.

Article 31: Complaint Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a policy on complaints. The procedure for making complaints was clearly outlined and there was a nominated person for dealing with complaints. The complaints log was inspected. Complaints were recorded in good detail and it was evident that complaints were responded to in a timely manner. A complaints leaflet was available and the complaint procedure displayed. The nature of some complaints conveyed the impression that more robust daily processes for ensuring that residents feel listened to might deflect the perceived need for many of the complaints, which were minor in nature.

Article 32: Risk Management Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X		X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*		X	
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a risk management policy in place. Individual clinical files were inspected and a risk assessment had been carried out. There was a broad risk management plan in place for these.

Article 33: Insurance

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The approved centre was fully insured as required by the Regulations and the certificate of the 14 February 2012 was inspected.

Article 34: Certificate of Registration

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The certificate of registration was displayed in the entrance foyer.

2.3 EVIDENCE OF COMPLIANCE WITH RULES – MENTAL HEALTH ACT 2001 SECTION 52 (d)

SECLUSION

Use: Seclusion was not used in the approved centre and there was a policy to state this.

Electroconvulsive Therapy (ECT) (DETAINED PATIENTS)

Use: Electroconvulsive therapy was not used in the approved centre. At the time of inspection, no detained patients were in receipt of ECT at another hospital.

MECHANICAL RESTRAINT

Use: Mechanical restraint under Part 5 of the Rules Governing the Use of Mechanical Restraint was used by the approved centre.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
1	General principles	NOT APPLICABLE			
14	Orders	NOT APPLICABLE			
15	Patient dignity and safety	NOT APPLICABLE			
16	Ending mechanical restraint	NOT APPLICABLE			
17	Recording use of mechanical restraint	NOT APPLICABLE			
18	Clinical governance	NOT APPLICABLE			
19	Staff training	NOT APPLICABLE			
20	Child patients	NOT APPLICABLE			
21	Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour	NOT APPLICABLE			

Justification for this rating:

No resident was mechanically restrained in the approved centre up to the time of inspection..

2.4 EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

PHYSICAL RESTRAINT

Use: Physical restraint was used in the approved centre.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
1	General principles	X			
5	Orders		X		
6	Resident dignity and safety	X			
7	Ending physical restraint	X			
8	Recording use of physical restraint		X		
9	Clinical governance	X			
10	Staff training		X		
11	Child residents	NOT APPLICABLE			

Justification for this rating:

Owendoher: The clinical files of four residents who had been restrained and the Clinical Practice Form book were inspected. The episodes were recorded in the clinical files and there was evidence that the episode had been subsequently discussed with the resident in at least one case. The Clinical Practice Forms were not all fully completed.

Kylemore: No resident had been restrained since 2010.

Swanbrook: No resident had been physically restrained since the unit opened.

Staff training in the therapeutic management of violence and aggression had not been updated and completed for all staff. Two staff had been trained as trainers and were due to train staff in the forthcoming months.

Breach: 5.7(c),8.3, 10.1

ADMISSION OF CHILDREN

Description: Children were not admitted to the approved centre.

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

Description: There had been no deaths in 2012 up to the time of inspection.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
2	**Notification of deaths**	**NOT APPLICABLE**			
3	**Incident reporting**	**X**			
4	**Clinical governance (identified risk manager)**	**X**			

Justification for this rating:

The approved centre reported all incidents and any deaths to the Mental health Commission. No resident had died in 2012 to the time of inspection.

The risk management policy met the requirements of Article 32 of the Regulations and there was an identified risk manager in place.

The record of incidents was inspected and was in order.

Electroconvulsive Therapy (ECT) FOR VOLUNTARY PATIENTS

Use: The approved centre did not administer ECT. At the time of inspection no voluntary resident was in receipt of ECT at another hospital.

ADMISSION, TRANSFER AND DISCHARGE

Part 2 Enabling Good Practice through Effective Governance

The following aspects were considered: 4. policies and protocols, 5. privacy confidentiality and consent, 6. staff roles and responsibility, 7. risk management, 8. information transfer, 9. staff information and training.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
	X		

Justification for this rating:

There was an admission, transfer and discharge policy. The centre was fully compliant with Article 32 of the Regulations on risk management. There was an excellent checklist relating to information and transfer procedures.

The policies relating to residents' personal property and the ordering and storing of medications were out of date.

There was a policy in relation to the care and management of individuals with an intellectual disability and mental illness.

Breach: 4.10, 4.11

Part 3 Admission Process

The following aspects were considered: 10. pre-admission process, 11. unplanned referral to an Approved Centre, 12. admission criteria, 13. decision to admit, 14. decision not to admit, 15. assessment following admission, 16. rights and information,17. individual care and treatment plan, 18. resident and family/carer/advocate involvement, 19. multidisciplinary team involvement, 20. key-worker, 21. collaboration with primary health care community mental health services, relevant outside agencies and information transfer, 22. record-keeping and documentation, 23. day of admission, 24. specific groups.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
		X	

Justification for this rating:

Owendoher: The clinical file of one resident recently admitted was inspected. The referral had come from another agency and the decision to admit was made by the consultant psychiatrist. A psychiatric assessment was carried out on admission but the resident did not have an individual care plan. The service did not have a key worker system in place, but was in the process of training health care assistants in this aspect of care. Kylemore had an identified key worker on the board for all residents but looking at the individual files it did not operate as a key worker as defined under section 20 of the Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre.

Inspection of individual clinical files indicated that a physical examination was not necessarily recorded at time of admission. Each resident did not have an individual care plan in accordance with Article 15 of the Regulations.

Breach: 15.3, 17.1, 20.4

Part 4 Transfer Process

The following aspects were considered: 25. Transfer criteria, 26. decision to transfer, 27. assessment before transfer, 28. resident involvement, 29. multidisciplinary team involvement, 30. communication between Approved Centre and receiving facility and information transfer, 31. record-keeping and documentation, 32. day of transfer.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
	X		

Justification for this rating:

Owendoher: The clinical file of one resident who had been transferred to a general hospital was inspected. The decision to transfer the resident was made by the GP who documented this in the clinical file. A copy of the transfer form and the doctor's letter were retained in the clinical file.

Donnybrook: The clinical files of two residents transferred to general hospitals were reviewed. Documentation was in order in one file, but there was no copy of the transfer form or doctor's letter in the second clinical file.

Swanbrook: The decision to transfer was taken by the general practitioner or consultant psychiatrist. A transfer form accompanied the resident as well as a letter from the medical practitioner.

Kylemore: The individual clinical file of one resident who had been transferred to another hospital for treatment and who had since returned to the approved centre, was inspected. The decision to transfer by the general practitioner and a copy of the transfer form and medical letter were all on file, and a medical report from the treating hospital was retained in the file also.

Breach: 31.2

Part 5 Discharge Process

The following aspects were considered: 33. Decision to discharge, 34. discharge planning, 35. pre-discharge assessment, 36. multi-disciplinary team involvement, 37. key-worker, 38. collaboration with primary health care, community mental health services, relevant outside agencies and information transfer, 39. resident and family/carer/advocate involvement and information provision, 40. notice of discharge, 41. follow-up and aftercare, 42. record-keeping and documentation, 43. day of discharge, 44. specific groups.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
NOT APPLICABLE			

Justification for this rating:

No resident had been discharged from the approved centre in 2012 to the time of inspection.

HOW MENTAL HEALTH SERVICES SHOULD WORK WITH PEOPLE WITH AN INTELLECTUAL DISABILITY AND MENTAL ILLNESS

Description: There was one resident with intellectual disability in Owendoher ward. Staff reported that two residents in Kylemore ward had an intellectual disability.

The following aspects were considered: 5. policies, 6. education and training, 7. inter-agency collaboration, 8. individual care and treatment plan, 9.communication issues, 10. environmental considerations, 11. considering the use of restrictive practices, 12. main recommendations, 13. assessing capacity.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
	X		

Justification for this rating:

It was reported that no specific training in the care of people with intellectual disability was given to staff. Two senior nurses in Owendoher ward had training and experience in working with people with intellectual disability. The individual clinical file of one individual with an intellectual disability on Kylemore ward was inspected and there was an individual care plan in place.

There was a policy on the care and management of individuals with an intellectual disability and mental illness.

Breach: 6

2.5 EVIDENCE OF COMPLIANCE WITH SECTIONS 60/61 MENTAL HEALTH ACT 2001 (MEDICATION)

SECTION 60 – ADMINISTRATION OF MEDICINE

Description: Six patients detained under the Mental Health Act 2001 were receiving medication for the purpose of ameliorating their mental disorder and for a period in excess of three months.

SECTION	FULLY COMPLIANT	NOT COMPLIANT
Section 60 (a)	**NOT APPLICABLE**	
Section 60 (b)(i)	**X**	
Section 60 (b)(ii)	**X**	

Justification for this rating:

Owendoher: There were two detained patients on this ward who had been administered medication for longer than three months. Form 17 was signed and in date in each case.

Donnybrook: A Form 17 was signed and in date in respect of one patient administered medication for longer than three months.

Kylemore: There was one detained patient on this ward who was in receipt of medication for longer than three months and an up-to-date Form 17 was on file.

Swanbrook: There were two detained patients on this ward who had been administered medication for longer than three months. Form 17 was signed and in date in each case.

SECTION 61 – TREATMENT OF CHILDREN WITH SECTION 25 MENTAL HEALTH ACT 2001 ORDER IN FORCE

Description: As children were not admitted to the approved centre, Section 61 of the Mental Health Act did not apply.

SECTION THREE: OTHER ASPECTS OF THE APPROVED CENTRE

SERVICE USER INTERVIEWS

Residents were greeted by inspectors throughout the course of the visit. Several residents spoke with inspectors and stated that they were satisfied with the accommodation, meals and the standard of their individual care.

OVERALL CONCLUSIONS

Overall the quality of individual care plans was poor in relation to psychosocial functioning. Not all residents had an individual care plan. Data capturing a sense of individuals as holistic, autonomous agents with a life history, preferences and values, and a sense of future was generally scant or absent in the individual clinical files. In 17 of 18 individual care plans inspected, only one evidenced input from the resident. The exception to this was in relation to those residents seen for individual occupational therapy, where records captured the residents voice, preferences and a sense of past, present and future. Bloomfield impressed as having a caring ethos and the respect afforded individuals was evident in the environment, the catering and the attitude of staff. The residents who spoke with the inspectors all expressed satisfaction with their care. At present, the only evidence of service user voice was the complaints log. Individual care plans must, as far as practicable, include the service user. Service users should also be supported in exercising their capacity by being provided with information relating to their healthcare.

An excellent recreational programme was provided for residents and the activities coordinator had won the Irish Nursing Homes award for best activity coordinator in 2011. Therapeutic interventions needed to be linked to assessed need and specified in individual care plans. There was a sense that in general, the programmes provided were more akin to a comprehensive nursing home programme than to an approved centre. Bloomfield has 112 beds and provides care for individuals with enduring mental illness. Consideration should be given to the development of a recovery oriented service with appropriate talking therapies and clearly identified clinical care pathways. A fully resourced multidisciplinary team might support this.

Significant changes had taken place recently in Bloomfield: consultant psychiatrist input had increased, general practitioner input had increased and a new chief executive officer, with clinical experience, had been appointed and there were plans to develop clinical governance. Many of the recommendations below had been identified by the approved centre management team as being priorities.

RECOMMENDATIONS 2012

1. Each resident must have an individual care plan as specified in Article 15 of the Regulations (previously recommended in 2011).

2. Therapeutic services and programmes must be specified in individual care plans and delivered accordingly.

3. The range and number of health and social care professionals must be adequate to meet the assessed needs of residents.

4. Staff training in relation to physical restraint, and also in relation to working with persons with an intellectual disability and mental illness must be updated (previously recommended in 2011).

5. Physical assessment on admission should be recorded in the individual clinical file.

6. All policies required by the Mental Health Act 2001 (Approved Centres) Regulations 2006 (S.I. No. 551 of 2006) must be up to date.

7. Information on diagnosis, medication and treatments must be provided for residents (previously recommended in 2011) with a service-user friendly format and content.