Report of the Inspector of Mental Health Services 2011

EXECUTIVE CATCHMENT AREA	Independent Hospital
HSE AREA	Independent Hospital
MENTAL HEALTH SERVICE	Independent Hospital
APPROVED CENTRE	Bloomfield Care Centre – Donnybrook, Kylemore, Owendoher & Swanbrook Wings
NUMBER OF WARDS	3 (one ward not operational)
NAMES OF UNITS OR WARDS INSPECTED	3
TOTAL NUMBER OF BEDS	88
CONDITIONS ATTACHED TO REGISTRATION	None
TYPE OF INSPECTION	Unannounced re-inspection
DATE OF INSPECTION	18 August 2011

OVERVIEW

In 2011, the Inspectorate paid particular attention to Articles 15 to 22 and 26 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 and all areas of non-compliance with the Regulations in 2010 and any other Article where applicable.

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 2010. Information was 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 on the outskirts of Dublin on the south side. It was inspected in April 2011 and was found to be not compliant with section 60 Mental Health Act 2001. The approved centre was informed of this non-compliance and a second unannounced inspection was carried out on 18 August 2011. Other areas where full compliance had not been achieved in the April 2011 inspection were also re-inspected.

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

COMPLIANCE RATING	2009	2010	APRIL 2011	AUGUST 2011
Fully Compliant	26	24	25	26
Substantial Compliance	2	3	3	2
Minimal Compliance	2	2	0	0
Not Compliant	0	1	2	2
Not Applicable	1	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
Kylemore	28	28	Psychiatry of Old Age
Owendoher	24	22	Psychiatry of Old Age
Donnybrook	36	36	Psychiatry of Old Age
Swanbrook	closed	closed	closed

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 15: Individual Care Plan

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	APRIL 2011	AUGUST 2011
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	X

Justification for this rating:

A sample of clinical files was examined on Kylemore, Owendoher and Donnybrook wards. Only one resident in Donnybrook ward had an individual care plan as defined in the Regulations. The approved centre had introduced an individual care plan for one resident on Donnybrook ward on a pilot basis. It was the intention of the approved centre to roll out these individual care plans throughout the centre.

Breach: 15

Article 16: Therapeutic Services and Programmes

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	APRIL 2011	AUGUST 2011
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	X		
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			X	X

Justification for this rating:

There was evidence from the clinical files examined that each resident had access to an appropriate range of therapeutic services and programmes but as all residents, apart from one, did not have an individual care plan as defined in the Regulations, these therapeutic services and programmes were not in accordance with the residents' individual care plans.

Breach: 16(1)

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

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	APRIL 2011	AUGUST 2011
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	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:

Written information on diagnoses and on indications for use of all medications to be administered to residents, including any possible side-effects was now available in the approved centre on each ward.

Article 26: Staffing

WARD OR UNIT	STAFF TYPE	DAY	NIGHT
Owendoher	CNM2	1	0
	Staff nurses	2	1
	Care assistants	4	2
	Special observation nurse	1	1 until midnight.
Kylemore	CNM2	1	0
	CNM1	1	0
	Staff nurses	2	1
	Care assistants	4	2
Donnybrook	CNM2	1	0
	Staff nurses	2	1
	Care assistants	4-5	2

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Non Consultant Hospital Doctor (NCHD).

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	APRIL 2011	AUGUST 2011
Fully compliant	*Evidence of full compliance with this Article.*	X			
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*		X	X	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 remained limited access to social work through the residents' original mental health service.

Breach: 26(2)

Article 32: Risk Management Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	APRIL 2011	AUGUST 2011
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	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 risk management policy had remained unchanged since the April 2011 inspection in that it had not been updated to include policies on suicide and self-harm.

Breach: 32(2) (c) (ii)

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

PHYSICAL RESTRAINT

Use: No resident had been physically restrained in Donnybrook and Kylemore since the last inspection in April 2011. One resident in Owendoher ward had been physically restrained.

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:

There was evidence in the clinical file that physical restraint in this case was used only after all alternative interventions to manage the resident's unsafe behaviour had been considered. There was written evidence in the clinical file that the resident's next of kin had been informed of the episode of physical restraint. The use of physical restraint was clearly recorded in the resident's clinical file. The completed Clinical Practice Form had not been placed in the resident's clinical file. The approved centre did not have a policy and procedures for training staff in relation to physical restraint. Three members of staff were commencing the Control and Restraint Instructors course in September 2011 and following completion of this would then train the approved centre's staff in control and restraint and breakaway techniques.

Breach: 8.3, 10.

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

Description: Seven deaths were reported by the approved centre since 1 January 2011 to the date of inspection.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
2	**Notification of deaths**	X			
3	**Incident reporting**		X		
4	**Clinical governance**		X		

Justification for this rating:

The risk management policy had not been updated to include policies on suicide and self-harm and so, remained not compliant with Article 32 of the Regulations.

Breach: 3.1, 3.2, 4

ADMISSION, TRANSFER AND DISCHARGE

Description: The approved centre admitted and transferred residents. At the time of re-inspection there had been no discharges from the approved centre in 2011.

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:

The risk management policy had not been updated since the April 2011 inspection to include policies on suicide and self-harm and so, remained not compliant with Article 32 of the Regulations. There remained no protocol for the admission and discharge of persons with an intellectual disability and mental illness.

Breach: 4.16, 7.1

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:

The assessment of the resident on admission did not include a risk assessment. Every resident did not have an individual care plan.

Breach: 15.3, 17.1

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:

In the clinical files of three residents who had been transferred either to another approved centre or a general hospital, there were no copies of the referral letters or transfer forms in the residents' clinical files.

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:

It was reported that no resident had been discharged.

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

Description: Two residents in Kylemeore had an intellectual disability and mental illness.

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:

The approved centre was working on the initial phase of a draft policy and protocols to reflect the principles in this Code of Practice (*Guidance for Persons working in Mental Health Service with People with Intellectual Disabilities*). Education and training had not been provided to support the principles and guidance in this Code of Practice. Neither of these residents had an individual care plan.

Breach: 5, 6, 8

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

SECTION 60 – ADMINISTRATION OF MEDICINE

Description: Five patients were detained under the Mental Health Act 2001 for a period longer than three months. All of these patients were being administered medicine for the purposes of ameliorating their mental disorder.

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

Justification for this rating:

There was documentary evidence in the clinical files of all five patients that the continued administration of medicine was approved by the consultant psychiatrist responsible for the care and treatment of the patients and that the continued administration of medicine was authorised in Form 17 by another consultant psychiatrist.

SECTION THREE: OTHER ASPECTS OF THE APPROVED CENTRE

SERVICE USER INTERVIEWS

Residents were greeted but no resident requested to speak with the Inspectorate.

OVERALL CONCLUSIONS

An unannounced re-inspection of Bloomfield Care Centre was carried out over three months after the initial inspection of April 2011. During the April 2011 inspection the approved centre was found to be not compliant with section 60 Mental Health Act 2001. Following this re-inspection, the approved centre was compliant with section 60.

The level of compliance with Article 20 (Provision of Information to Residents) reached full compliance.

The approved centre continued to be non-compliant with Article 15 (Individual Care Plan) and as a consequence, was not compliant with Article 16 (Therapeutic Services and Programmes). Full compliance with Articles 26 (Staffing) and Article 32 (Risk Management Procedures) had also not been achieved. The service remained not fully compliant with the Codes of Practice on Physical Restraint, Notification of Deaths and Incident Reporting, Admission, Transfer and Discharge to and from an Approved Centre and Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities.

RECOMMENDATIONS 2011

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

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

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

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

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.

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