Report of the Inspector of Mental Health Services 2009

MENTAL HEALTH SERVICE	St. John of God Hospital
APPROVED CENTRE	St. John of God Hospital Limited
CATCHMENT AREA	Independent Sector
NUMBER OF WARDS	8
NAMES OF UNITS OR WARDS INSPECTED	St. Peter's St. Joseph's Carraigfergus Ginesa
TOTAL NUMBER OF BEDS	183 (including 12 adolescent beds)
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	10 and 11 March 2009

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

DESCRIPTION

St. John of God Hospital Ltd. was a private not-for-profit independent teaching hospital located in South County Dublin. It had well-maintained private grounds that facilitated a range of outdoor and recreational and sporting activities. The hospital provided in-patient care and treatment for Chluain Mhuire public mental health service as well as for private referrals from all parts of the country. The hospital provided a number of specialty services, including alcohol and addiction, psychosis, eating disorders, psychiatry of later life and adolescent in-patient assessment and treatment.

DETAILS OF WARDS IN THE APPROVED CENTRE

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
St. Peter's	18	18	General adult
St. Paul's	34	34	General adult
St. Joseph's	32	32	General adult
St. Camillus's	27	23	General adult
St. Brigid's	20	20	General adult
Carraigfergus	24	24	Psychiatry of later life
Carraig Dubh	16	16	Psychiatry of later life
Ginesa	12	12	Adolescent

QUALITY INITIATIVES

- The St. Peter's review process had got under way. The first part, which examined population, staff skills mix, function of unit and clinical structures, had been completed. The second part, examining a detailed unit-based programme, the mix of group and individual work to be provided and integration of disciplines, was in progress.
- Upgrading work was completed on St. Peter's and St. Paul's. It included the upgrading of the ECT suite and seclusion facilities, and access to an internal garden.
- A gymnasium had been completed. Assessment of relevant staff skills mix was being undertaken in order to get it up and running.
- Clinical audits were undertaken on a regular basis on a range of issues.
- A lift had been installed and this facilitated elderly residents to access the chapel.
- There had been a significant investment in technology for the communication of information. The hospital web site had been upgraded. A mental health information system had been developed and was being rolled out on a pilot basis. The hospital intranet had been developed. Policies and documents were uploaded to the system as they were reviewed.
- The hospital had attained hospital accreditation and quality standards (HAQU) accreditation.
- The child and adolescent team had established links with St. Patrick's Hospital and TCD in developing a generic course in child and adolescent mental health.

PROGRESS ON RECOMMENDATIONS IN THE 2008 APPROVED CENTRE REPORT

1. The individual care plans must be enhanced to ensure compliance with the Regulations (Article 15). The care plans should document the extent of multidisciplinary team working that takes place within the service. The keyworker role could be expanded to enhance the current care plan process, particularly in relation to documentation and evaluation of the care plan as discussed above. (This was also a recommendation in 2007.)

Outcome: Although there were ongoing audits and refinements of the individual care plan, the current system was not compliant with the Regulations. While there was clear evidence that regular team meetings and ward rounds were held, it was not clearly documented which of the multidisciplinary team members attended, nor were specific members identified as responsible for following through on particular decisions made by the team. The clinical files reviewed by the Inspectorate did not specify the treatment and care required, identify goals, necessary resources or specify appropriate goals for the residents as described in the Regulations. In Ginesa, while each of the young people had individual multidisciplinary team care plans and multidisciplinary team review of progress, these had not been filed in the clinical charts for some time. The utility of the care plans was questionable if they were not easily accessible to the team.

2. The six monthly physical reviews of residents must be completed (Article 19). The Inspectorate recommended that the hospital put in place a system to ensure that these review dates are flagged, completed and documented.

Outcome: The service reported that an alert system had been incorporated into the Hospital's *Mental Health Information System* whereby consultants were advised of those patients who remained under their in-patient care and were due a six monthly physical review. The files reviewed during inspection indicated that residents had received general health examinations at least every 6 months.

3. Episodes of seclusion and physical restraint must be fully documented in residents' clinical files as set out in the relevant rules and codes of practice. The Inspectorate noted that some services had developed a checklist to help ensure that all the requirements in relation to documentation were observed.

Outcome: The service had devised a checklist for staff but this had not been introduced at the time of inspection. The problems identified last year were evident in the clinical files reviewed during this year's inspection.

4. Information to resident's should include provision of information on all multidisciplinary team members involved in their care and treatment, not just medical and nursing, routine verbal and written information about their diagnosis (unless there is a risk to the resident or other), and routine information on indications for use of all medications and possible side effects (Article 20). The Inspectorate would expect that in circumstances where this was not done, the reason would be documented in the clinical file.

Outcome: Some wards had displayed the names of the members of the multidisciplinary team on the walls in a way that was very accessible to residents. This information was not available to residents on St. Peter's Ward.

5. The hospital had introduced a bracelet for the identification of residents. Staff on St. Peter's reported that residents who were acutely ill or paranoid removed their own bracelets from time to time. The Inspectorate recommended that the practice of using identification bracelets on St. Peter's be reviewed, in light of the difficulties for some residents. A less intrusive system for identification of residents may be more suitable.

Outcome: This issue remains a problem for a small number of residents on St. Peter's Ward.

6. The management team should be enhanced to include heads of the health and social care professionals in line with A Vision for Change, the national mental health policy. This was also a recommendation from 2007.

Outcome: The recommendation had not been progressed. The CEO advised that the organisation was not aware of any difficulties with the current management structure and the organisation was

focusing on developing its clinical structures. The organisation reported that membership of St. John of God Hospital Limited Management Team was determined by its Board of Directors. Periodic reviews of the hospital's organisational structures ensured representation of all clinical and support disciplines in the operation and strategic development of hospital services.

7. The needs of forensic patients should be addressed within an appropriate environment and treatment setting. (A recommendation arising from the 2007 report)

Outcome: It was reported that there were two residents with significant forensic histories who were inappropriately placed in the hospital. Referrals had not been made to more appropriate settings and the outcome of assessments was not available on the day of inspection. The two residents inappropriately placed in St. John of God continue to reside in the hospital. The service continues to attempt to place one of these residents in a more suitable unit whilst the other resident was awaiting a judicial review on their placement.

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	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

The hospital operated two systems of identification. On the adult wards, residents were given an identification bracelet at admission. On the adolescent unit, photographs were included in the clinical files of the young person.

Article 5: Food and Nutrition

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

On St. Peter's Ward, jugs of water were available for residents. There was a choice of food available at meal times and preferences and special diets were catered for.

Article 6 (1-2) Food Safety

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

The last Environmental Health Officer's report highlighted issues to be addressed and indicated that a follow-up inspection would be carried out within six weeks. No follow-up report was available. The service submitted written confirmation that all of the deficits highlighted in the report had been addressed.

Article 7: Clothing

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

A supply of spare clothing was available in emergencies. Petty cash was available for the purchase of items of clothing, toiletries or personal items. None of the residents were nursed in night clothes.

Article 8: Residents' Personal Property and Possessions

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

The service had a policy in place. A record of personal property was taken at admission. A copy was available to the resident, a copy was kept in inventory book, and a copy was placed in the clinical file. Personal lockers and wardrobes were available and potentially hazardous items were stored securely by nursing staff.

Article 9: Recreational Activities

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

St. Peter's Ward had quiet sitting areas, with books and games available. There were TV areas. As this ward was locked, staff-accompanied walks were provided three times a day after breakfast, dinner and tea. Window painting was evident and this added a personal and seasonal touch to the ward.

Article 10: Religion

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

The religious beliefs of residents were recorded at admission. The hospital chaplains were available to liaise with residents and their families to facilitate religious needs. There was a chapel in the hospital. The chaplains visited the wards daily to enhance their accessibility to the residents. Pastoral care for residents of faiths not catered for by the chaplains was readily available.

Article 11 (1-6): Visits

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

There were a number of areas on the wards, the hospital cafeteria and the grounds that could be used for visits. Specific visiting times were indicated on the ward leaflets given to residents and families at admission. On St. Peter's Ward, the occupational therapy room could be used to facilitate visits by children. As the ward was locked, visitors were given access by nursing staff who were then in a position to check what was being brought onto the ward.

Article 12 (1-4): Communication

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

The service had a policy on communication. Post was easily accessed by residents through the CNM2. Mobile phones were not allowed on St. Peter's. A public phone was provided on the ward and use of the office phone if necessary.

Article 13: Searches

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*	X	
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

The service had written policies and procedures for searches. One clinical file on St. Peter's Ward was reviewed. The reason for and the background to the search had been recorded. Consent of the resident was not recorded in the clinical file reviewed. The name of staff involved in the search was not recorded. There was no record that the resident was informed of what was happening and why. The hospital had developed a checklist that had not been in operation at the time of inspection.

Breach: Article 13 (4), Article 13 (6), and Article 13 (8).

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

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

The hospital had policies in place. There had been no deaths since January 2009.

Article 15: Individual Care Plan

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		X
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*	X	
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

Each resident did not have an individual care plan as defined in the Regulations.

There was evidence that regular team meetings and ward rounds were held, but it was not always clear which of the multidisciplinary team members attended, nor were specific members identified to follow through on particular decisions made by the team. The clinical files reviewed by the Inspectorate did not specify the treatment and care required, identify goals, necessary resources or specify appropriate goals for the residents as described in the Regulations.

In Ginesa Ward, while each of the young people had individual multidisciplinary team care plans and multidisciplinary team reviews of progress, these had not been filed in the clinical charts for some time. The utility of the care plans was questionable if they were not easily accessible to the team.

Breach: Article 15 (3)

Article 16: Therapeutic Services and Programmes

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*	X	
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

A number of therapeutic services were available through the occupational therapy and clinical psychology departments. Some residents attended specific groups and the department was able to offer specialised groups due to an increase in the number of clinical psychologists in the service. The occupational therapy department also provided a range of activities to residents. However, in the absence of an individual care plan that meets the Regulations, the provision of therapeutic services to individual residents was not linked to an appropriate care plan.

Breach: Article 16 (1)

Article 17: Children's Education

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*	X	
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		X
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

The educational needs of children were assessed; however, the service has not had access to a teacher since December 2008. Funding was earmarked for a teaching post and the service had been planning to fill it in January 2009 but there has been no further progress from the Department of Education and Science. That there was no educational service provision was a serious situation given that the service had a dedicated young persons unit.

Breach: Article 17

Article 18: Transfer of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

The service had policies regarding the transfer of residents between wards and also from St. John of God Hospital to other hospitals.

Article 19 (1-2): General Health

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*	X	
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

The files reviewed on St. Peter's Ward and St. Joseph's Ward indicated compliance with this Article.

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

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*	X	
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

Some wards had the names of the staff on the multidisciplinary teams on display, but details of residents' multidisciplinary team were not available on St. Peter's Ward. Written information on diagnosis was not available routinely to residents. Information on medications including side effects was not routinely provided to residents. All wards had leaflets explaining practical arrangements. Staff reported that verbal information about diagnosis and medication was provided by psychiatrists and nursing staff. Posters and leaflets about voluntary agencies and the Irish Advocacy Network were displayed on the wards.

Breach: Article 20 (1)(a), Article 20 (1)(c), and Article 20 (1)(e).

Article 21: Privacy

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

The level of privacy afforded to residents was excellent and the high standard of the premises facilitated this.

Article 22: Premises

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

Premises were maintained in good order and were regularly cleaned. Recent renovations in some wards had been completed. Fittings and furnishings were of a very high standard. The accommodation staff had won a national award for accommodation services.

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

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

Medications were stored in the medicine trolley on the ward and where necessary, medications were kept in a locked fridge. Medications were dispensed in the presence of two staff. Staff were conscious of the need to protect residents' privacy in relation to receiving medications. Policies were in place relating to ordering, prescribing, storing and administering medications.

Article 24 (1-2): Health and Safety

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

There was a policy in place relating to the health and safety of staff, residents, and visitors.

Article 25: Use of Closed Circuit Television (CCTV)

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

CCTV cameras were in use in the service in corridors and some communal areas, but for monitoring purposes only. Cameras were not used for recording residents. Signs indicating its use were evident throughout the premises.

Artticle 26: Staffing

WARD OR UNIT	STAFF TYPE	DAY	NIGHT
St. Joseph's	Nurse	5	2
St. Peter's	Nurse	6	3

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

Management reported that the service was now at full nursing staff complement. All multidisciplinary teams had a complement of health and social care professionals attached, although these were often shared across teams and were not solely dedicated to specialty areas, making it difficult to develop an expertise in a particular area.

Article 27: Maintenance of Records

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*	X	
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

All records viewed by the Inspectorate were up to date and easily retrieved. The service had policies relating to maintenance of records. A copy of food safety inspections report conducted in 2007 was seen, as was the insurance certificate for 2009. The centre had no record of fire inspections.

Breach: Article 27 (3)

Article 28: Register of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

Not all information as indicated in Schedule 1 was kept on the register. The PPS number was not recorded. There was additional information available on the computerised documentation relating to residents.

Breach: Article 28 (c)

Article 29: Operating Policies and Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

Not all policies were reviewed within the appropriate timescale. The policies on seclusion and physical restraint had not been reviewed since 2007 and were required to be reviewed annually.

Breach: Article 29

Article 30: Mental Health Tribunals

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

The service cooperated with mental health tribunals.

Article 31: Complaint Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

Residents were informed about the approved centre policy concerning complaints on admission. There were procedures on verbal and written complaints and these were discussed at regular communal meetings held on the wards for residents. Information on complaints was also available on the ward notice boards.

Article 32: Risk Management Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

The risk management policy did not specifically address the precautions in place to control risk of suicide and self-harm. The risk management policy could be enhanced by inclusion of the admissions policy which forms part of the clinical risk management process.

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

Article 33: Insurance

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

The service had up-to-date insurance arrangements in place.

Article 34: Certificate of Registration

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

The certificate of registration was displayed in the entrance hall.

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

SECLUSION

Use: Seclusion was used only on St. Peter's Ward, which had a suite of two seclusion rooms ,an observation area and bathroom facilities. The facilities had been upgraded to a high standard.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
2	Orders			X	
3	Patient dignity and safety	X			
4	Monitoring of the patient	X			
5	Renewal of seclusion orders	X			
6	Ending seclusion	X			
7	Facilities	X			
8	Recording	X			
9	Clinical governance			X	
10	Staff training	X			
11	CCTV	X			
12	Child patients	X			

Justification for this rating:

The clinical files and register indicated seclusion episodes were being recorded with details required under the Rules missing. There was no record that the reason for and likely duration of seclusion were explained to the patient, that next of kin were informed of seclusion, or that the seclusion episode was discussed with multidisciplinary team.The policy was not reviewed annually. The approved centre had a checklist of all details required but this had not been implemented at the time of inspection.

Breach: Article 2.9, Article 2.10, Article 9.1 (d), and Article 9.2.

ECT (DETAINED PATIENTS)

Use: One clinical file was reviewed and the ECT suite and equipment were inspected.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
2	Consent	X			
3	Information	X			
4	Absence of consent	X			
5	Prescription of ECT	X			
6	Patient assessment	X			
7	Anaesthesia	X			
8	Administration of ECT	X			
9	ECT Suite	X			
10	Materials and equipment	X			
11	Staffing	X			
12	Documentation	X			
13	ECT during pregnancy	NOT APPLICABLE			

.Justification for this rating:

The standard of recording in relation to ECT was good. The equipment was well maintained and the ECT suite had been recently upgraded to a high standard.

MECHANICAL RESTRAINT

The Inspectorate was informed that mechanical restraint was not used in the approved centre, and there was a policy to this effect in the documentation seen.

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

PHYSICAL RESTRAINT

Use: The approved centre used different techniques for physical restraint depending on whether it was being used with adult or adolescent patients. There was a comprehensive policy and staff training schedule.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
2	Orders			X	
3	Resident dignity and safety	X			
4	Ending physical restraint	X			
5	Recording use of physical restraint		X		
6	Clinical governance			X	
7	Staff training	X			
8	Child residents	X			

Justification for this rating:

Review of the clinical files and physical register indicated that episodes of seclusion were being recorded with some omissions of details required under the Rules. Two forms had not been signed off by the consultant and as a result were not filed in the resident's clinical chart but remained in the register. There was no record that residents had been informed of the reasons for and likely duration of physical restraint, that resident's next of kin had been informed, or that the episodes of physical restraint had been reviewed by the multidisciplinary team. The approved centre had developed a checklist which included all the detail required in the code of practice but this had not been implemented at the time of inspection. The policy on physical restraint had not been reviewed annually.

Breach: Section 2.8, Section 2.9, Section 2.10, Section 5.3, Section 6.1(d), and Section 6.2.

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ADMISSION OF CHILDREN

Description: The approved centre had a dedicated young person's unit with a dedicated multidisciplinary team. All admissions since January 2009 had been voluntary.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
2	**Admission**			X	
3	**Treatment**	X			
4	**Leave provisions**	X			

Justification for this rating:

The clinical files reviewed indicated consent for admission and treatment. There was a programme of therapeutic and recreational activities provided linked to care plans. Age-appropriate educational facilities were not provided.

Breach: Section 2.5 (b)

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

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

.Justification for this rating:

The risk management policy could be enhanced by inclusion of the admissions policy which forms part of the clinical risk management process. The risk management policy did not specifically address the precautions in place to control risk of suicide and self harm.

Breach: Section 3.1 (2)(c)

ECT FOR VOLUNTARY PATIENTS

Use: The ECT suite had been upgraded and the premises and facilities for ECT were of a high standard.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
2	Consent	X			
3	Information	X			
4	Prescription of ECT	X			
5	Assessment of voluntary patient	X			
6	Anaesthesia	X			
7	Administration of ECT	X			
8	ECT Suite	X			
9	Materials and equipment	X			
10	Staffing	X			
11	Documentation	X			
12	ECT during pregnancy	X			

Justification for this rating:

In the files reviewed, there was evidence of compliance with the Rules relating to the administration of ECT.

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

SECTION 60 – ADMINISTRATION OF MEDICINE

In the files reviewed by the Inspectorate, the administration of medication to patients for a period of time in excess of three months was compliant with the Rules.

SECTION 61 – TREATMENT OF CHILDREN WITH SECTION 25 ORDER IN FORCE

No medication had been administered to a child admitted under Section 25, so Section 61 was not applicable.

SECTION THREE: OTHER ASPECTS OF THE APPROVED CENTRE

SERVICE USER INTERVIEWS

At the beginning of the inspection process, staff were asked to inform residents that the Inspectorate team was available to speak with any resident and a specified time was set aside. No resident availed of the opportunity.

OVERALL CONCLUSIONS

The internal and external facilities available to the residents' families and staff were excellent. There had been meticulous attention to detail in the design and upgrading of the wards and garden areas.

The developments in computerised technology were exciting and presented opportunities for residents and managers. The system provided significant avenues for enhancing flexibility, accessibility and communication and could include alerts and prompts to help compliance with the Regulations, Rules and Codes of Practice, for example in prompting six-monthly physical examinations or in alerting staff about the requirements associated with seclusion when recording an episode of seclusion on the electronic charts.

The hospital had developed a number of checklists for searches, seclusion and physical restraint and the introduction of these would likely increase compliance with the requirements of the relevant Regulations, Rules and Codes of Practice and would facilitate audit and monitoring of compliance.

The management structure remained unchanged and heads of discipline of clinical specialities were not part of the senior management team, despite the recommendations of the *A Vision for Change* policy document. Heads of discipline were active in the clinical governance committee and their views were represented at management level by the clinical director.

RECOMMENDATIONS 2009

1. Individual care plans must be introduced for each resident. (Also a recommendation in 2008 and 2007)

2. The approved centre must provide information for residents in relation to diagnosis and medication. (Also a recommendation in 2008) Administrative support must be adequate to ensure clinical information was filed promptly in clinical files.

3. Seclusion details must be fully recorded in the clinical files. (Also a recommendation in 2008)

4. Physical restraint details must be fully recorded in the clinical files. (Also a recommendation in 2008)

5. The composition of the management team should be reviewed in line with *A Vision for Change*. (Also a recommendation in 2008 and 2007)

6. The system for identification of residents on St. Peter's unit should be reviewed to ensure that it was appropriate for the residents there. (Also a recommendation in 2008)

7. Staffing of multidisciplinary teams should include dedicated health and social care professionals in order to facilitate development of expertise in specialist areas.

8. The register of residents should be amended to gather all the information specified in Schedule 1 of the Regulations.

9. The development of the intranet system should include a facility for alerting the approved centre when policies are due for review. The service was required to review policies at least every three years or as specified by the Inspectorate or the Rules and Codes of Practice.

10. The risk management policy must specifically address the precautions in place to control risk of suicide and self harm and should include reference to the admissions policy.