

# Report of the Inspector of Mental Health Services 2008

<b>HSE AREA</b>	HSE West
<b>CATCHMENT</b>	Mayo
<b>MENTAL HEALTH SERVICE</b>	Mayo
<b>APPROVED CENTRE</b>	Adult Mental Health Unit, Mayo General Hospital
<b>NUMBER OF UNITS OR WARDS</b>	1
<b>UNITS OR WARDS INSPECTED</b>	Department of Psychiatry
<b>NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED</b>	32
<b>CONDITIONS ATTACHED TO REGISTRATION</b>	No
<b>TYPE OF INSPECTION</b>	Announced
<b>DATE OF INSPECTION</b>	9 October 2008

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

### INTRODUCTION

In 2008, there was a focus on continuous quality improvement across the Mental Health Service. 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 2007. Information was gathered from service user questionnaires, staff interviews and photographic evidence collected on the day of the inspection.

### DESCRIPTION

The Department of Psychiatry was a 32-bed unit attached to the General Hospital in Mayo. It had five sector teams, a psychiatry of later life team and a new rehabilitation team. The catchment area had a population of 123,648 with a wide geographical area.

<b>WARD</b>	<b>NUMBER OF BEDS</b>	<b>NUMBER OF RESIDENTS</b>	<b>TEAM RESPONSIBLE</b>
Dept. of Psychiatry	32	32	Sector teams

The unit was well maintained. There was no high observation area and, although the unit had an open door policy, the door into the unit was locked most of the time.

### RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. *The MDT care plans should include all the work undertaken by all members of the multidisciplinary team.*

**Outcome:** Although there was integrated files and a care plan, there was no evidence that it was multidisciplinary and no staff member was identified as being responsible for different aspect of the care plan.

### MDT CARE PLANS 2008

The nursing staff used the Tidal model of nursing and this was well maintained and comprehensive. All sectors held weekly team meetings, either in the unit or in the sector headquarters. Unit nursing staff did not attend

clinical meetings held outside the unit but sent verbal reports for inclusion at the meeting. Multidisciplinary staff attended the weekly review meetings. The multidisciplinary care plan specified goals and review dates but did not designate the staff responsible for implementing the care plan. There was no evidence of any input from the multidisciplinary team in the care plans that were inspected. It was reported that a review of the care plan would take place in the near future.

### **GOOD PRACTICE DEVELOPMENTS 2008**

- The Tidal model of nursing had been introduced and all nursing care plans were up to date.
- The service were in the process of applying for Electroconvulsive Therapy Accreditation Service (ECTAS) accreditation for ECT.
- A rehabilitation consultant had been appointed.
- Excellent information leaflets had been developed for different facilities throughout the catchment area.
- There was notable enthusiasm and interest in developing the service from all staff on the day of inspection, with instances of staff initiatives over and above the minimum requirements necessary for compliance.

### **SERVICE USER INTERVIEWS**

No service user wished to speak with the Inspectorate

### **2008 AREAS FOR DEVELOPMENT ON THE QUALITY, CARE AND TREATMENT MENTAL HEALTH ACT 2001 SECTION 51 (b)(i)**

1. There needs to be full engagement by all staff with the multidisciplinary care planning process. The current care plan requires to be reviewed and identified deficits corrected.
2. All stakeholders should address the concerns raised about the non-availability of out-of-hours services for child and adolescent mental health and child protection services.

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

In 2008, the inspection focused on areas of non-compliance identified in 2007. In addition, the Inspectorate re-inspected compliance with all the Articles in Part Three of the Regulations (15–21 and 26) and the Rules and the Codes of Practice in each approved centre. In 2008, two new Codes of Practice were issued and compliance with them was inspected. Where conditions were attached, they were inspected in detail. Evidence of compliance was established through three strands:

- Inspection of compliance where there was a breach in 2007. This was cross-referenced with the action plan submitted to the MHC Standards and Quality Assurance Division.
- Written evidence requested prior to the inspection, for example policies.
- Evidence gathered during the course of the inspection from staff, service users, photographic evidence and photocopies.

### **2.1 EVIDENCE OF COMPLIANCE WITH CONDITIONS ATTACHED TO REGISTRATION**

As no conditions were attached, this was not applicable.

### **2.2 EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d) ON 9 OCTOBER 2008**

#### **Article 15: Individual Care Plan**

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Each resident had a Tidal model nursing care plan and also a multidisciplinary individual care plan that was recorded in an integrated file. Staff responsible for interventions were not identified and therefore this did not meet the requirements of this Article in that it did not specify the necessary staff resources and requirements to implement the care plan. Some care plans were not completed. It was indicated that a planned review of care planning would take place shortly and a working group had been set up.

**Breach:** The care plan did not specify what resources were required to implement the care plan. Some care plans were incomplete.

**Compliant:** No

#### **Article 16: Therapeutic Services and Programmes**

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There was a comprehensive activity programme that was run by nursing staff. Each resident attended according to their specified needs and a report was recorded in the clinical file.

**Compliant:** Yes

#### **Article 17: Children's Education**

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Children were admitted to the unit. Children could attend their own school if this was indicated.

**Compliant:** Yes

#### **Article 18: Transfer of Residents**

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There was a policy concerning transfer of residents to hospitals and other approved centres.

**Compliant:** Yes

**Article 19 (1-2): General Health**

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No resident was in the unit for longer than six months. Staff were aware of the requirement for six-monthly physical reviews.

**Compliant:** Yes

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

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An excellent information leaflet was available that outlined both household arrangements and specific details about residents' clinical teams. There was also a leaflet on nursing care. Information about diagnoses and medication was available on request. There was a policy on the provision of information.

**Compliant:** Yes

**Article 21: Privacy**

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There were screens around the beds and a number of single rooms were available. The unit had segregated bathing and sleeping facilities for men and women.

**Compliant:** Yes

**Article 26: Staffing**

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The HSE national policies in relation to recruitment selection and vetting of staff applied to the unit. A record of nursing staff on duty was kept on the unit.

The following table provides a summary of the current unit staffing levels.

STAFF TYPE	DAY	NIGHT
Nurse	8 (variable)	5
Care assistant	0	0

Staff had access to the nursing education centre on the grounds of St. Mary's Hospital, which ran a range of courses. A booklet about all courses for nursing was available. All staff had trained in the Mental Health Act. Copies of the Act, Regulations, Rules and Codes of Practices were all available in the nurses' station on the unit. A record of training was available.

**Compliant:** Yes

**Article 28: Register of Residents**

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The register of residents contained all information specified in the Regulations.

**Compliant:** Yes

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

### SECLUSION

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Rules for the Use of Seclusion.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	Orders	Compliant. All seclusion orders were signed by the consultant and the seclusion register was in order.
3	Patient dignity and safety	Compliant. The seclusion room was in a main corridor but had access to a toilet nearby.
4	Monitoring of the patient	Compliant
5	Renewal of seclusion orders	Not applicable
6	Ending seclusion	Compliant
7	Facilities	Compliant. The seclusion room was ventilated and well lit. The appropriate safety facilities were in place.
8	Recording	Compliant. The seclusion register was in order.
9	Clinical governance	There was a policy on seclusion in place.
10	Staff training	Compliant. There was record of training in management of aggression available in the unit. The majority of staff had been trained and refresher courses were ongoing.
11	CCTV	Compliant. This was in use in the seclusion room and was clearly labeled.
12	Child patients	Not applicable

**Compliant:** Yes

## ECT

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In general, the ECT facilities and process were excellent.

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Rules for the Use of ECT.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	<b>Consent</b>	Compliant. An adequate consent form for both treatment and anaesthesia was in operation.
3	<b>Information</b>	Compliant. An excellent information leaflet was available
4	<b>Absence of consent</b>	Not applicable
5	<b>Prescription of ECT</b>	Compliant
6	<b>Patient assessment</b>	Compliant
7	<b>Anaesthesia</b>	Compliant
8	<b>Administration of ECT</b>	Compliant
9	<b>ECT Suite</b>	The ECT suite had a waiting area, treatment room and recovery room. The treatment room was well-equipped. The recovery room had all necessary equipment.
10	<b>Materials and equipment</b>	All materials and equipment was present.
11	<b>Staffing</b>	There was a designated consultant and an ECT nurse.
12	<b>Documentation</b>	All documentation was in order.
13	<b>ECT during pregnancy</b>	Not applicable

**Compliant:** Yes

## MECHANICAL RESTRAINT

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Staff reported that no mechanical restraint had been used on the unit. A written operational policy and procedures on mechanical restraint were in place. Staff also reported that mechanical restraint for enduring self-harm had not been used.

**Compliant:** Not applicable

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

### PHYSICAL RESTRAINT

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Code of Practice for the Use of Physical Restraint.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	Orders	Compliant
3	Resident dignity and safety	Compliant
4	Ending physical restraint	Compliant
5	Recording use of physical restraint	Compliant. The register was in order and correctly signed.
6	Clinical governance	Compliant
7	Staff training	Compliant
8	Child residents	Not applicable

**Compliant:** Yes

### ADMISSION OF CHILDREN

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Code of Practice for the Admission of Children under the MHA 2001.

RULE	DESCRIPTION	COMPLIANCE REPORT
2	Admission	Since January 2008 fourteen children had been admitted. A consultant in child and adolescent psychiatry was available for consultation. A policy was available on the admission of children to the unit.
3	Treatment	All children admitted had been on one-to-one nursing. There was no specific programme in place for children or adolescents. Concern was expressed that there was no out-of-hours service for children from either the Child and Adolescent Mental Health Services (CAMHS) or Child Protection Social Work Services. As this was an adult unit with no high observation unit it was not appropriate for the admission of children.
4	Leave provisions	Compliant

**Breach:** Section 2.5

**Compliant:** No

## NOTIFICATION OF DEATHS AND INCIDENT REPORTING

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Code of Practice for the Notification of Deaths and Incident Reporting.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	Notification of deaths	There were no deaths in the unit in 2008.
3	Incident reporting	Compliant. All incidents were reported.
4	Clinical governance	Compliant. There was a policy in place. Reports of incidents were regularly reviewed and were available.

**Compliant:** Yes

## ECT FOR VOLUNTARY PATIENTS

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Code of Practice for the Use of ECT for Voluntary Patients.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	Consent	Compliant. An adequate consent form for both treatment and anaesthesia was in operation.
3	Information	Compliant. An excellent information leaflet was available for residents.
4	Prescription of ECT	Not applicable
5	Assessment of voluntary patient	Compliant
6	Anaesthesia	Compliant
7	Administration of ECT	Compliant
8	ECT Suite	The ECT suite had a waiting area, treatment room and recovery room. The treatment room was well-equipped. The recovery room had all the necessary equipment.
9	Materials and equipment	All materials and equipment was present.
10	Staffing	There was a designated consultant and ECT nurse.
11	Documentation	All documentation was in order.
12	ECT during pregnancy	Not applicable

**Compliant:** Yes

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

This was not applicable.

**Compliant:** Not applicable