Report of the Inspector of Mental Health Services 2008

HSE AREA	HSE West
CATCHMENT	Clare
MENTAL HEALTH SERVICE	Clare
APPROVED CENTRE	Acute Psychiatric Unit, Midwestern Regional Hospital, Ennis
NUMBER OF UNITS OR WARDS	1
UNITS OR WARDS INSPECTED	Acute Psychiatric Unit
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	39
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	10 July 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.

The Inspectorate met with the CNM3 on the unit and a feedback meeting was facilitated after the inspection, which was also attended by other clinical staff and managers. During the inspection, the Inspectorate asked to meet with representatives of the health and social care professionals prior to completion of the inspection but this was not facilitated.

DESCRIPTION

The acute psychiatric unit was located in the general hospital in Ennis. On the day of inspection, the unit was locked. Voluntary residents could come and go freely past the receptionist. The unit had 34 general beds and five beds for psychiatry of later life.

On the day of the inspection, there were 36 residents and an additional three were on leave from the unit. There were ten detained patients. Four general adult teams, the psychiatry of later life team and the rehabilitation team could admit to the unit.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Acute Psychiatric Unit	39	36	4 general adult 1 Rehabilitation 1 Psychiatry of Later Life

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. The unit should continue to develop fully-integrated multidisciplinary team care planning.

Outcome: On the day of inspection, there had been no progress since last year's report. Subsequently the service had reported that a sub-committee has been established to review best practice in relation to MDT care planning and hope to recommend a system to be implemented in September 2008.

2. The complaints procedure should be made more visible to residents.

Outcome: The complaints procedure was displayed prominently in the unit.

3. The seclusion room door was of a poor standard and ventilation was inadequate. Both need urgent rectification.

Outcome: Staff reported that a new door had been ordered and was expected to be delivered within the next two months. The ventilation issue had not been progressed although staff reported that the problem was not as significant since the high observation area had been unlocked and in any event the seclusion room had not been in use. However it remained an outstanding issue.

4. CCTV signage should be clearly labeled and be evident to ensure disclosure of its existence and usage.

Outcome: CCTV signage was prominently displayed on the unit.

5. The replacement of venetian blinds due to the string ligatures should be considered in favour of more adequate and suitable fittings.

Outcome: This process had begun and was ongoing and some blinds had been replaced. A number of venetian blinds remained on the windows and the Inspectorate continued to have concern in relation to the risk they pose to residents.

6. The high windows in the bedrooms of the high observation area should be curtained as outside lights shone through them at night.

Outcome: Some of these windows had been upgraded with mechanical blinds installed. There were plans to install mechanical blinds in the seclusion rooms and to change the window in one room and put curtains on it.

MDT CARE PLANS 2008

In last year's report, the Inspectorate identified that the system in use required only minor adjustment to meet with the requirements of Articles 3 and 15 on individual care planning. This involved including a section for identifying goals and having all disciplines on the teams contributing input to the double-sided care planning form that was in the clinical files.

However, the Inspectorate was informed that this system did not meet the needs of the various disciplines and a multidisciplinary working group had been set up late the previous year to progress the introduction of an agreed comprehensive care planning process including assessment. At the time of this inspection, the residents still did not have an individual care plan that met with the requirements of the Regulations (Articles 3 and 15). There were records of multidisciplinary team meetings in the clinical files reviewed. A record of attendance at multidisciplinary team meetings was kept separate to the resident's clinical file. The clinical notes did not document a set of goals and the service users were not given a copy of their individual care plans.

The approved centre had a written policy in relation to individual care plans which indicated a requirement for all disciplines to complete the existing MDT care plan (yellow form). In the clinical files reviewed it was evident that apart from nursing staff, none of the other disciplines involved with the residents' care and treatment were using these forms.

Subsequently the service had reported that the sub-committee established to review best practice in relation to MDT care planning hoped to recommend a system to be implemented in September 2008.

GOOD PRACTICE DEVELOPMENTS 2008

- The approved centre had developed a comprehensive risk management policy and procedures and had actively involved the clinical risk manager in this process.

- The approved centre had developed a detailed safety statement and completed a safety audit of the unit which had resulted in some changes in practice, such as the unlocking of the high observation area.

- The approved centre had invested substantial personnel and financial resources in progressing training for staff in the area of prevention and management of violence and aggression. A number of staff have been trained as trainers and a plan had been developed to roll out the training to all staff over the coming months. Trainers hoped initially to complete assessments of need for specific areas and teams and then design and deliver specific packages of training appropriate to the assessed needs.

- Nursing staff had completed an audit of six clinical files and the results had been disseminated to staff on the unit.

- The first-ever hygiene audit of the unit had been completed.

- An external evaluation of the Refocusing Project was completed and the results were presented at a conference.

- The activation nurse in conjunction with the health promotion department had completed an evaluation of smoking on the unit and following presentation of the outcomes, residents had been involved in designing anti-smoking posters for the unit.

SERVICE USER INTERVIEWS

None of the residents asked to speak to the Inspectorate.

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

1. Each resident must have an individual care plan as defined in the Regulations.

2. The risk posed to residents from the venetian blinds should be acted on promptly and the remaining blinds be replaced immediately.

3. The progress in upgrading the seclusion facility should continue, in particular the risk issues on seclusion identified in Section 2 (3) of this report should be addressed as soon as possible.

4. The approved centre's children's education policy should be amended to reflect the procedure that the service liaises with the child's parents in relation to educational requirements.

5. The record of complaints should be amended to include the date the complaint was received.

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

INTRODUCTION

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 10 JULY 2008

Article 6 (1-2) Food Safety

This was inspected and was in order.

Compliant: Yes

Article 7: Clothing

It was reported to the Inspectorate that night clothes were only worn by residents if documented in the clinical file. One resident was nursed in night clothes on the day of inspection. The nursing care plan specified this on the advice of the consultant psychiatrist.

Compliant: Yes

Article 8: Residents' Personal Property and Possessions

A personal property book was in place. The unit had a policy on personal property and possessions.

Compliant: Yes

Article 15: Individual Care Plan

Nursing care plans were up to date and there were records of multidisciplinary team meetings in the clinical files reviewed.

Breach: Residents did not have an individual care plan as required under Article 15 and defined in Article 3. Subsequently the service reported that a sub-committee had been established to review best practice in relation to MDT care planning and hoped to recommend a system to be implemented in September 2008.

Compliant: No

Article 16: Therapeutic Services and Programmes

There was a programme in place facilitated by the activation nurse. The programme was not linked to individual care plans as they were not in place.

Breach: The programme was not linked to individual care plans [Article 16 (1)].

Compliant: No

Article 17: Children's Education

Staff reported that they generally liaised with a child's parents in relation to educational requirements. The Inspectorate recommended that this be included in the approved centre's policy on children's education. One child had attended school from the unit during admission.

Compliant: Yes

Article 18: Transfer of Residents

The approved centre was compliant.

Compliant: Yes

Article 19 (1-2): General Health

Two residents were in the approved centre for more than six months and they both had six-monthly physical examinations completed.

Compliant: Yes

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

Each sector had its own dedicated information leaflet. It was reviewed and updated every six months as the NCHDs changed. Verbal information on diagnosis and medication was provided by the key worker, NCHD or consultant. Information sessions were provided through the activation programme. Information leaflets on diagnoses were available in the activation area.

A member of the Irish Advocacy Network (IAN) visited the unit on a regular basis. The activation nurse facilitated a medication information meeting weekly. The unit had a written operational policy on the provision of information to relatives.

Compliant: Yes

Article 21: Privacy

The unit was compliant with this Article.

Compliant: Yes

Article 24 (1-2): Health and Safety

The unit had a comprehensive health and safety statement.

Compliant: Yes

Article 26: Staffing

The HSE West recruitment department had written policies and procedures relating to the recruitment, selection and vetting of staff. The assistant director of nursing and the CNM3 ensured an appropriate skill mix of nursing staff appropriate to the assessed needs of the residents. It was reported that the skill mix of the teams was appropriate to meet the needs of the residents. Although there was a strong commitment to provide training, releasing staff to undertake training was reported as a problem.

Three nurses had completed the Prevention and Management of Aggression and Violence (PMAV) course in Dundalk Institute of Technology and were now planning to train the staff in the unit. There has been a concerted effort by management and practice development to facilitate this training and the service is commended for this proactive approach. All staff received regular training in basic life support, manual handling and preceptorship. All staff had undergone the Mental Health Act training course. There was a copy of the Act, the Regulations and the Rules on the unit and available to all staff.

Compliant: Yes

Article 27: Maintenance of Records

All clinical files examined were current and in good order. Documentation of inspections relating to food safety, health and safety and fire inspections were available on the unit.

Compliant: Yes

Article 29: Operating policies and procedures

The policies had a date of implementation and a date for review.

Compliant: Yes

Article 31: Complaint Procedures

The CNM3 was the nominated complaints officer. The nominated person maintained a record of all complaints relating to the unit. The complaints record was reviewed by the Inspectorate. The date that the complaint was received should be added to the record. The complaints procedure was prominently displayed in the unit.

Compliant: Yes

Article 32: Risk Management Procedures

The service has worked with the local risk manager in developing comprehensive risk management policies and procedures. A hazards risk assessment was completed on a regular basis and a record of outcomes was kept. The Inspectorate commended the approved centre for its comprehensive risk management strategy.

Compliant: Yes

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

SECLUSION

Two clinical files of patients authorised for seclusion and the seclusion register were reviewed by the Inspectorate. In both cases the recording of information relating to the seclusion episodes was detailed and complete. The approved centre had a policy on seclusion. The Inspectorate draws attention to the requirement under Section 9.1(d) of the Rules Governing the Use of Seclusion that the policy be reviewed at least annually.

The seclusion room door remained of a poor standard. The Inspectorate was informed that a new door has been ordered. A covered socket that remained in the seclusion room was not live. The seclusion room had a false ceiling with fluorescent lighting. Both of these could be a potential risk. On the day of the inspection, ventilation in the seclusion room, which relied on wind circulation of natural air, was inadequate. The unit has a written operational policy and procedures relating to the use of seclusion. The room required a means of blocking out daylight and it was reported that there were plans to install mechanical blinds.

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
3	**Patients' dignity and safety**	Compliant
4	**Monitoring of the patient**	Compliant
5	**Renewal of seclusion orders**	Compliant
6	**Ending seclusion**	Compliant
7	**Facilities**	Non-compliant (see above)
8	**Recording**	Compliant
9	**Clinical governance**	Compliant
10	**Staff training**	Non-compliant. A programme of training was planned but not yet in place.
11	**CCTV**	Compliant
12	**Child patients**	Not applicable

Breach: Section 7 and Section 10. Although training was planned staff were not in receipt of training on the day of inspection.

Compliant: No

ECT

ECT had not been administered to detained patients. The approved centre had an ECT suite.

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	**Consent**	Not applicable
3	**Information**	Not applicable
4	**Absence of consent**	Not applicable
5	**Prescription of ECT**	Not applicable
6	**Patient assessment**	Not applicable
7	**Anaesthesia**	Not applicable
8	**Administration of ECT**	Not applicable
9	**ECT Suite**	Compliant
10	**Materials and equipment**	Compliant
11	**Staffing**	Compliant
12	**Documentation**	Not applicable
13	**ECT during pregnancy**	Not applicable

Compliant: Yes

MECHANICAL RESTRAINT

The Inspectorate was informed that mechanical restraint was not used on the unit. This was in line with the approved centre's policy. The policy was implemented in November 2007 with a review date for 2010.

Compliant: Not applicable

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

PHYSICAL RESTRAINT

The clinical practice forms were being completed and corresponding information was recorded in the resident's clinical file. The approved centre had a policy on physical restraint. The Inspectorate draws attention to the requirement under Section 6 (1)(d) of the Code of Practice on the Use of Physical Restraint that the policy be reviewed at least annually.

Three nurses had completed the Prevention and Management of Violence (PAMV) course in Dundalk Institute of Technology and were now planning to train the staff in the unit.

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
6	**Clinical governance**	Compliant
7	**Staff training**	Non-compliant. A programme of training was planned.
8	**Child residents**	Compliant

Breach: Although training was planned staff were not in receipt of training on the day of inspection [Section 7].

Compliant: No

ADMISSION OF CHILDREN

The file of one child who had been admitted was reviewed.

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.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Admission**	Non-compliant. All new staff had undergone Garda vetting and a process of Garda vetting for existing staff had commenced but was not yet completed. The service reported that accessing age appropriate advocacy services was difficult. The policy review group had been requested to develop a policy requiring each child to have a risk assessment but no timeframe for completion of this was available.
3	**Treatment**	Compliant. Parental consent had been given for treatment.
4	**Leave provisions**	Compliant. Leave was granted where appropriate.

Breach: Not all staff had undergone Garda vetting [Section 2.5(d)(i)]. Staff had not received training relating to the care of children [Section 2.5(e)]. There were no age appropriate advocacy services available [Section 2.5(g)]. The approved centre did not have a policy requiring each child to be individually risk assessed [Section 2.5(i)].

Compliant: No

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

The approved centre had a comprehensive risk management policy.

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**	Compliant
3	**Incident reporting**	Compliant
4	**Clinical governance**	Compliant

Compliant: Yes

ECT FOR VOLUNTARY PATIENTS

One voluntary patient had received ECT and the clinical file and ECT register were reviewed. All the documentation required was in order. There was a designated ECT nurse who was interviewed on the day of inspection and a designated consultant psychiatrist for ECT. Consultant anaesthetists attended ECT from the general hospital.

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
3	**Information**	Compliant
4	**Prescription of ECT**	Compliant
5	**Assessment of voluntary patient**	Compliant
6	**Anaesthesia**	Compliant
7	**Administration of ECT**	Compliant
8	**ECT Suite**	Compliant
9	**Materials and equipment**	Compliant
10	**Staffing**	Compliant
11	**Documentation**	Compliant
12	**ECT during pregnancy**	Compliant

Compliant: Yes

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

A number of clinical files of detained patients were reviewed and Section 60 requirements were in order. All admissions of children had been voluntary; therefore Section 61 was not applicable.

Compliant: Yes