Report of the Inspector of Mental Health Services 2008

HSE AREA	HSE West
CATCHMENT	Sligo/Leitrim/South Donegal
MENTAL HEALTH SERVICE	Sligo/Leitrim
APPROVED CENTRE	Ballytivnan Sligo/Leitrim Mental Health Services
NUMBER OF UNITS OR WARDS	3
UNITS OR WARDS INSPECTED	Special Care Female Admissions Male Admissions
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	52
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	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.

The Inspectorate facilitated a feedback meeting at the end of the inspection with ward staff, nursing managers, the clinical director and hospital manager.

DESCRIPTION

The approved centre was located in Ballytivnan and shared grounds with the local Institute of Technology. The Special Care and Male Admissions units were located on the ground floor. The Special Care unit had access to an enclosed garden area. The Male Admissions unit had an outdoor smoking area attached. The Female Admissions unit, which was locked on the day of inspection, was located on the first floor. The entrance area and corridors in the Female Admissions unit were being painted at the time of the inspection. Some upgrading work had been completed on the Male Admissions unit.

There were a number of residents on the Special Care unit who had been there for a number of years and there were no community facilities or alternatives to in-patient care available. All of the residents in the Special Care unit were detained and provision of therapeutic programmes was hampered by the lack of suitable space and storage. A number of residents had challenging behaviour and specialist therapeutic services were not available to them. The occupational therapy area in the approved centre was in need of redevelopment. The kitchenette was too small to use with small groups and the equipment was dated. There was no running water available in the room used for art.

The approved centre did not to provide an independent advocacy service that was easily accessible to residents on the units on a routine basis and remained the only approved centre in the country that did not provide this

facility. Arrangements were in place for residents from Leitrim to access the Citizens Information Board on request and the service was working towards a similar arrangement for residents who came from Sligo.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Special Care	10	8	1 sector team
Female Admissions	21	19	5 sector teams 1 rehabilitation team 1 psychiatry of later life team 1 intellectual disability team 1 child and adolescent team
Male Admissions	21	14	5 sector teams 1 rehabilitation team 1 psychiatry of later life team 1 intellectual disability team 1 child and adolescent team

The service planned to reconfigure service provision in line with primary care networks and this would mean there would be three sector teams once this was accomplished.

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. Each resident should have an integrated care plan as defined in the Regulations. This must be introduced at the earliest possible date.

Outcome: Individual MDT care plans had been introduced and were in evidence in the files reviewed.

2. An independent advocacy service should be established for all residents. Agreement must be reached with an external agency to provide this service.

Outcome: Residents from Leitrim could access a representative from the Citizens Information Board on request. The service was trying to arrange a similar agreement for residents from Sligo. There was no independent advocacy service routinely visiting the approved centre.

MDT CARE PLANS 2008

Individual multidisciplinary care plans had been introduced and were in evidence in all of the clinical files reviewed. The forms used contained a place for documenting identified problems, action plan, review date, signature for each of the disciplines to carry out the action and a space for recording outcomes. The service informed the Inspectorate that there was a plan to provide residents with an opportunity to sign their care plan and to have a copy of it, but this was held up as there was no administrative support to copy the care plan.

Each team met weekly in the units. The residents were invited to attend the team meetings and it was reported that carers were increasingly invited to attend also. Prior to the team meeting, residents were given a sheet that indicated the team members who would be present during the meeting. The teams rotated responsibility for which team member completed the care plan on the day. In the clinical file, there was a stamp inserted into the contemporaneous notes that indicated which multidisciplinary team members were present at meetings.

GOOD PRACTICE DEVELOPMENTS 2008

- Residents were invited to attend the weekly multidisciplinary team meeting and were given a sheet prior to team meetings that indicated the team members who would be present.

- The occupational therapists had reviewed and updated the therapeutic programmes provided by them on the units.

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. Privacy issues on the units in relation to observation panels should be addressed.

2. Advocacy services should be provided that are easily accessible to residents and service users should be included in the running of the service.

3. Funding should be provided to ensure that the multidisciplinary teams are fully resourced and the mix of disciplines was in accordance with the needs of the residents and national mental health policy.

4. The Special Care unit would benefit from an outdoor smoking area similar to that provided in the Male Admissions unit.

5. Funding should be made available to progress the plans for a purpose-built unit in Sligo General Hospital.

6. Individual care plans could be enhanced by facilitating the signing of the care plan by the resident and provision of a copy of the care plan to them.

7. The remaining refurbishment work on the Male Admissions unit should be completed, including the upgrading of the shower room, creation of a wheelchair-accessible toilet, relocation of a bath, and redecoration of areas affected by damp.

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 13: Searches

A policy on searches was in place.

Compliant: Yes

Article 15: Individual Care Plan

Each resident had an individual care plan.

Compliant: Yes

Article 16: Therapeutic Services and Programmes

Two occupational therapists were based on the wards full time and they facilitated a therapeutic programme and individual sessions over five days. The programme was based on an individual assessment and was linked to the overall integrated care plan.

A pharmacist and a pharmacy technician attended the wards on a regular basis. They attended the special care ward meeting and reviewed the drug card index on a regular basis. There was access to limited social work and psychology services.

Compliant: Yes

Article 17: Children's Education

Children admitted to the approved centre were under the care of the child and adolescent team. Educational requirements were addressed through liaison with parents, schools and the National Educational Psychology Service.

Compliant: Yes

Article 18: Transfer of Residents

Policies and procedures were in place.

Compliant: Yes

Article 19 (1-2): General Health

A number of residents on the wards had been present for more than six months. A number of files were examined and there was no documentation to indicate that these had been completed. Following the inspection, the service reported that it would carry out an audit to identify any residents who had not yet had physical reviews in order to assist with compliance on this Article.

Breach: Physical reviews were not completed [Article 19 (1)].

Compliant: No

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

A comprehensive information leaflet was provided for residents. Information about multidisciplinary teams was included and there was written information about diagnosis and the provision of medication. Advocacy arrangements were not in place for all residents and details of relevant advocacy agencies were not provided. Following the inspection, the service reported that work was continuing to arrange for residents to have details of relevant advocacy agencies and that information regarding the advocacy service in Leitrim was available in the patient information leaflet.

Breach: Details of advocacy agencies were not provided [Article 20 (1)(d)].

Compliant: No

Article 21: Privacy

A small number of bedrooms did not have net curtains in place and the wards looked directly out on a public car park area. Many of the bedroom doors on the corridor had glass observation panels and there was no facility to cover these, for example blinds or curtains that would allow for privacy and still facilitate observation when required. In the Special Care unit, two of the toilet cubicles were found to have observation slots in the door and photographic evidence was taken. Following the inspection, the service reported that work was continuing to address privacy issues.

Breach: Observation panels should be removed from the toilet cubicles and there should be a means of covering other observation panels.

Compliant: No

Article 22: Premises

The approved centre consisted of an old two-storey building that was not designed for its purpose. A number of problems identified in the previous year's report in the Male Admissions unit had not been progressed and required action. These included the upgrading of the shower room, creating a wheelchair-accessible toilet, relocation of a bath and redecoration in areas affected by damp. The outdoor smoking area had been completed. The building was clean, bright and heated. There was a lift in place. In the Special Care unit there was an outdoor smoking area and even though there was a smoking room, the smoke permeated through the unit. Following the inspection, the service reported that work was continuing to address the required upgrading work highlighted in last year's report.

Breach: Some work specified in last year's report had yet to be completed.

Compliant: No

Article 26: Staffing

A central roster was in place that allocated staff on a daily basis to one of the three wards. One basic grade and one acting senior occupational therapists were based on the ward full time. All other staff provided sessions and consultations to residents on the ward as required. The teams did not have a full complement of health and social care professionals who could input to the approved centre.

Breach: The skill mix of staff was not appropriate to the needs of the residents.

Compliant: No

Article 29: Operating policies and procedures

The approved centre had a system for reviewing and amending policies.

Compliant: Yes

Article 32: Risk Management Procedures

The service did not have a comprehensive risk management policy, although the risk management group was working on this area.

Breach: No comprehensive policy existed [Article 32 (1)].

Compliant: No

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

SECLUSION

Seclusion was used only in the Special Care unit. 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**	Non-compliant. There was no documentation that the patient was informed of the reason for, or likely duration of, seclusion [Section 2.9] or whether next of kin were informed [Section 2.10].
3	**Patient dignity and safety**	Compliant
4	**Monitoring of the patient**	Compliant
5	**Renewal of seclusion orders**	Compliant
6	**Ending seclusion**	Compliant
7	**Facilities**	Compliant
8	**Recording**	Compliant
9	**Clinical governance**	Non-compliant. No documentation of review of incident by MDT [Section 9.2].
10	**Staff training**	Compliant
11	**CCTV**	Compliant
12	**Child patients**	Not applicable

Following inspection the service reported that a planned audit of documentation would alert staff to the terms of the seclusion policy and assist with compliance.

Breach: Section 2.9, Section 2.10, and Section 9.2.

Compliant: No

ECT

No detained patients had received ECT since January 2008.

Compliant: Not applicable

MECHANICAL RESTRAINT

Staff reported that mechanical restraint was not in use on the wards and the policy reflected this. Staff reported that mechanical means of bodily restraint for enduring self-harming behaviour was not in use on the wards.

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**	Non-compliant. There was no evidence residents were informed about the reasons for, and likely duration of, restraint [Section 2.9] or whether next of kin were informed [Section 2.10].
3	**Resident dignity and safety**	Compliant
4	**Ending physical restraint**	Compliant
5	**Recording use of physical restraint**	Compliant
6	**Clinical governance**	Non-compliant. There was no evidence that episodes of physical restraint were reviewed by the multidisciplinary team [Section 6.2].
7	**Staff training**	Non-compliant. The policy did not include information about training as required [Section 7.1]. The Inspectorate highlighted the requirement for the policy to be reviewed annually [Section 7.1(d)].
8	**Child residents**	Not applicable

Following inspection the service reported that a planned audit of documentation would alert staff to the terms of the physical restraint policy and assist with compliance.

Breach: Section 2.9, Section 2.10, Section 6.2 and Section 7.1.

Compliant: No

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**	Non-compliant. Facilities were not age appropriate [Section 2.5(b)], although a room was being refitted as a day room to accommodate children. No age appropriate advocacy services were available [Section 2.5(g)].
3	**Treatment**	Compliant
4	**Leave provisions**	Compliant

Breach: Section 2.5(b) and Section 2.5(g).

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**	Compliant
3	**Incident reporting**	Non-compliant. The service did not have a comprehensive risk management policy, although the risk management group was working on this area [Section 3.1].
4	**Clinical governance**	Non-compliant. The risk management policy did not cover notification of deaths and incident reporting [Section 4.1]. It did not identify the risk manager or person with responsibility for risk management within the service [Section 4.2] and it did not identify the roles and responsibilities of staff in relation to reporting of deaths and incidents [Section 4.3].

Following the inspection, the service reported that the risk management policy was being updated by a dedicated team and that the updated policy would be submitted to the Mental Health Commission in the near future.

Breach: Section 3.1, Section 4.1, Section 4.2 and Section 4.3.

Compliant: No

ECT FOR VOLUNTARY PATIENTS

ECT was administered in Sligo General Hospital. The ECT suite there was not inspected.

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**	Not applicable
9	**Materials and equipment**	Not applicable
10	**Staffing**	Compliant
11	**Documentation**	Compliant
12	**ECT during pregnancy**	Not applicable

Compliant: Yes

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

Section 61 was not applicable. The clinical files reviewed were in order in relation to Section 60.

Compliant: Yes