

## Report of the Inspector of Mental Health Services 2008

<b>HSE AREA</b>	HSE West
<b>CATCHMENT</b>	East Galway
<b>MENTAL HEALTH SERVICE</b>	East Galway
<b>APPROVED CENTRE</b>	St. Brigid's Hospital, Ballinasloe
<b>NUMBER OF UNITS OR WARDS</b>	8
<b>UNITS OR WARDS INSPECTED</b>	Our Lady's Ward Unit 16 Unit 17 Unit 19 Unit 21 Unit 21a
<b>NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED</b>	65 Continuing Care 41 Acute Care
<b>CONDITIONS ATTACHED TO REGISTRATION</b>	No
<b>TYPE OF INSPECTION</b>	Announced
<b>DATE OF INSPECTION</b>	14 August 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. A feedback meeting was facilitated by the Inspectorate following the inspection.

#### **DESCRIPTION**

St. Brigid's Hospital was an old psychiatric hospital that had three admission wards and a number of continuing care wards. There had been significant progress over the previous three years to close the hospital and this had resulted in the closure of one block at the front of the hospital. The number of long-stay residents continued to fall and there were now 65 residents in long-stay wards. There was a comprehensive community service backed up by community residences.

The rehabilitation team had increased its staffing and was making progress in Unit 17 with care plans and therapeutic activities. The care plans reviewed in the other continuing care wards were of a very high standard. The admission units had not reached a satisfactory level of care planning.

The plans for the service and future of the admission units were not clear. There had been discussion about amalgamating East and West Galway but the Inspectorate could find no evidence that this had progressed since 2007.

The table below indicates the bed numbers and number of residents that were reported to the Inspectorate by staff on the relevant units on the day of inspection.

WARD	NUMBER OF RESIDENTS	SPECIALIST AREAS
Our Lady's Ward	14	admission
St. Dymphna's Ward	10	admission
St. Luke's Ward	11	admission
Ward 16	18	continuing care
Ward 17	13	rehabilitation
Ward 19	15	continuing care
Ward 21	12	continuing care
Ward 21A	9	continuing care

The service indicated in their factual corrections response that there were 65 residents in continuing care wards located in the structure described as the "New Building" and 41 acute beds, including 5 intensive care unit beds, and the breakdown of their figures by unit was also provided.

## RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

*1. Plans to close the remaining long-stay wards within St. Brigid's Hospital should continue with appropriate accommodation found for the remaining residents.*

**Outcome:** The progress on reducing the remaining long-stay wards continued. Ward 21A was due for closure in the near future.

*2. The rehabilitation team should be staffed fully as a matter of urgency.*

**Outcome:** There had been some progress in increasing the staffing of the rehabilitation team.

*3. A psychiatry of later life team should be put in place.*

**Outcome:** This had not happened. However a psychiatry of later life post had been advertised and a social work post had been approved. A dedicated occupational therapist, physiotherapist and CNM3 had been recruited to this team.

*4. Plans to develop and integrate East Galway and West Galway services should take into account the existing excellent community services and their accessibility for service users, the specialist functioning and skills of the mental health teams, and the provision of sub-specialty teams such as rehabilitation, liaison and psychiatry of later lives. All service users should have access to these services regardless of location.*

**Outcome:** No information on the status of the plans to amalgamate East and West Galway was made available to the Inspectorate. It appeared that the two catchment areas continued to function separately.

*5. The units should be accessible to people with limited mobility.*

**Outcome:** Unit 16 and the activity areas in the admission units were upstairs and there was no lift access.

## **MDT CARE PLANS 2008**

**Our Lady's Ward:** Integrated multidisciplinary care planning had not been introduced to Our Lady's. Staff appeared unaware of any plans to do so. Regular team meetings were held on the ward.

**Unit 16, Unit 17, Unit 19, Unit 21 and Unit 21A:** Integrated multidisciplinary care planning was in use. The format of the care plan was well laid out and there was medical, nursing, occupational therapy and physiotherapy input. Residents signed the care plan, when able, and retained a copy. The quality of the care plans reviewed was excellent. All residents in Unit 17 had care plans and the rehabilitation team had a programme of in-depth case reviews scheduled so that by the end of October all residents would have an up-to-date rehabilitation multidisciplinary recovery care plan.

## **GOOD PRACTICE DEVELOPMENTS 2008**

- A social worker had been recruited to the rehabilitation team.
- An occupational therapy post had been filled.
- In partnership with Portiuncula Hospital, the physiotherapists were doing a rotational six-month placement in St. Brigid's Hospital and were assigned to the psychiatry of later life team.
- A NCHD had been appointed to the continuing care units and visited the units regularly.
- Up-to-date clinical summaries were available in the integrated charts of the residents in the continuing care and rehabilitation units.

## **SERVICE USER INTERVIEWS**

The Inspectorate spoke to a number of residents. All stated that they were happy with the care they were receiving although one resident complained of feeling bored.

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

1. Integrated multidisciplinary care planning should be introduced as a matter of urgency to the admission unit. All staff should be kept up to date on the issue of multidisciplinary care planning. If necessary they should receive training in how to implement care planning.
2. Mandatory staff training must be completed as soon as possible. According to records supplied to the Inspectorate, only 24 of the 245 nursing staff had completed their initial training in management of violence and aggression. A lesser number of staff also require training in cardio-pulmonary resuscitation (CPR), first aid, and manual handling.
3. The programme of maintenance and cleaning must be enhanced in Our Lady's Ward.
4. There should be multidisciplinary participation in the activity area in the admission block to enhance the programme already offered. This should reflect individual needs of residents identified in care plans.
5. Some of the units in the continuing care area could benefit from access to enclosed outdoor areas.
6. The bathroom floor in Unit 17 requires attention. In its current condition it presents a trip hazard.
7. Privacy issues on some of the units, arising from observation panels in bedroom doors, should be addressed.

## **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 14 AUGUST 2008**

#### **Article 6 (1-2) Food Safety**

---

A food and hygiene statement of compliance with legislation with food and safety dated July 2007 was available.

**Compliant:** Yes

#### **Article 8: Residents' Personal Property and Possessions**

---

The policy on residents' personal property and possessions remained in draft form at the time of inspection.

**Our Lady's Ward and Unit 16:** Property was checked and itemised on admission with the resident and a property book was available. A facility for the safe keeping of valuables was available.

**Breach:** Article 8 (2)

**Compliant:** No

#### **Article 11 (1-6): Visits**

---

Policies on visiting remained in draft form.

**Our Lady's Ward:** The unit had an area that was used for visiting as well as other activities. However it was possible to have private visitation. During the inspection, it was observed that a child was visiting in the smoking area. It was brought to the attention of staff that the smoking room was not a safe environment for children.

**Unit 16:** There was no dedicated area for visiting. Visitors had to locate a quiet area of the ward or go downstairs to the grounds outside.

**Breach:** Article 11 (5) and Article 11 (6).

**Compliant:** No

### **Article 12 (1-4): Communication**

---

The policy on communication remained in draft form.

**Our Lady's Ward:** Neither incoming nor outgoing mail was unopened. A public phone was available. The use of mobile phones was allowed.

**Unit 16:** It was reported to the Inspectorate that the use of mobile phones by residents was not allowed.

**Breach:** Article 12 (3)

**Compliant:** No

### **Article 13: Searches**

---

The policies on searches and on the finding of illicit substances were in draft form at the time of inspection.

**Breach:** Article 13 (3)

**Compliant:** No

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

---

Policies on care of the dying remained in draft form.

**Our Lady's Ward:** Residents who became physically ill were transferred to Portiuncula Hospital.

**Unit 16:** A single room could be made available. It was reported to the Inspectorate that any resident whose physical condition deteriorated was usually transferred to Unit 19.

**Breach:** Article 14 (1)

**Compliant:** No

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

---

During 2007, the service had developed a comprehensive care plan that incorporated risk assessment.

**Unit 16, Unit 17, Unit 19, Unit 21 and Unit 21A:** These clinical areas were using individual care plans as defined in the Regulations, including risk assessment.

**Our Lady's Ward:** Despite the fact that care planning had been introduced in the continuing care and rehabilitation areas no care planning had commenced in the admission wards. Staff appeared to be unaware of the requirement to provide integrated care planning.

**Breach:** Article 15

**Compliant:** No

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

---

**Our Lady's Ward:** An activation department was located upstairs from the admissions unit and was run by nursing staff. Staff attended team meetings and recorded information in the clinical file. Occupational therapy provided individual assessments if required. Therapeutic activities were not linked to care plans, which were not in operation. There were plans to increase the input by other multidisciplinary members to the activation unit.

**Unit 16, Unit 17, Unit 19, Unit 21 and Unit 21A:** Therapeutic activities were linked to the resident's individual care plan.

**Breach:** Article 16

**Compliant:** No

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

---

Appropriate educational services for children were not provided.

**Breach:** Article 17

**Compliant:** No

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

---

A discharge letter, nursing report and summary accompanied residents on transfer.

The policy on transfer of residents remained in draft form at the time of inspection.

**Breach:** Article 18 (2)

**Compliant:** No

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

---

**Our Lady's Ward:** Access to general health services was available. One resident had not had a six-monthly review. This was brought to the attention of the staff.

**Unit 16, Unit 17, Unit 19, Unit 21 and Unit 21A:** There was evidence from the clinical files examined that not all of the six-monthly physical examinations had been completed.

**Breach:** Article 19 (1)(b)

**Compliant:** No

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

---

The service had an excellent information booklet incorporating general, sector, staff and personal information. This was also displayed in the activation unit. Information on sector teams, consultants, NCHDs and team nurses was also displayed on whiteboards that could be accessed by all residents and staff. The name and contact number of the Irish Advocacy Network (IAN) representative was also displayed.

**Compliant:** Yes

### **Article 21: Privacy**

---

**Our Lady's Ward:** All bed areas in the centre had curtains and individual storage space. However there were observation panels without curtains or blinds on doors of single rooms, which resulted in a lack of privacy for residents from anyone in the corridor while they were dressing or at any other time while in their bedrooms.

**Unit 16 and Unit 17:** There were observation panels without curtains or blinds on doors of single rooms, which resulted in a lack of privacy for residents from anyone in the corridor while they were dressing or at any other time while in their bedrooms.

**Breach:** Article 21

**Compliant:** No

### **Article 22: Premises**

---

Our Lady's Ward: The admission unit comprised of two wards; one upstairs and one downstairs. The windows in the bathroom and toilet areas were dirty, dusty and cobwebs were visible. There was a cracked mirror in the bathroom from which shards could be removed. There was a cracked window in a living area and scaffolding was awaited to remedy this. The Inspectorate was informed that this was toughened glass and did not pose a safety risk. The service reported that the glass had been ordered and would be fitted by the supplier.

**Breach:** Article 22 (1)(a)

**Compliant:** No

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

---

These policies were available.

**Compliant:** Yes

### **Article 24 (1-2): Health and Safety**

---

Health and safety statements were available. The Inspectorate was furnished with documentation that showed that the service was issued with an improvement order under Section 66 of the Safety, Health and Welfare at Work Act 2005, with extensions, due to contravention of Section 8 (2)(g) of the Safety, Health and Welfare at Work Act 2005. Correspondence between the Health and Safety Authority and the East Galway mental health service was continuing.

**Breach:** Article 24 (2)

**Compliant:** No

### **Article 25: Use of Closed Circuit Television (CCTV)**

---

CCTV was used solely in the external parts of the hospital and not within the hospital.

**Compliant:** Not applicable

**Article 26: Staffing**

---

Draft policies on staffing required implementation at the time of the inspection.

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

WARD OR UNIT	STAFF TYPE	DAY	NIGHT
Our Lady's Ward	RPN	2 plus 1 CNM2	2
Unit 16	RPN	2 plus 1 CNM2	2
	Attendants	2	0
Unit 17	RPN	1 plus 1 CNM2	2
	Attendants	0	0
Unit 19	RPN	2 plus 1 CNM2	2
	Attendants	2	0
Unit 21	RPN	2 plus 1 CNM2	2
	Attendants	2	1
Unit 21A	RPN	2	1
	Attendants	1	0

There was no regular input to the activation unit from multidisciplinary staff. Insufficient numbers of staff (24 out of 245 nursing staff and student nurses) had been trained in the management of aggression and violence.

**Breach:** Article 26 (4)

**Compliant:** No

**Article 27: Maintenance of Records**

---

The policies on maintenance of records were in draft form at the time of inspection. The clinical files were up to date and the care plans were in good condition.

**Breach:** Article 27 (2)

**Compliant:** No

**Article 29: Operating policies and procedures**

---

Most policies were in draft form at the time of the inspection. Many of the policies had no dates of implementation or review. The Inspectorate requested a statement to confirm that all policies that had been signed off and were operational, but this had not been received.

**Breach:** Most policies had not been signed off and were in draft form.

**Compliant:** No

### **Article 31: Complaint Procedures**

---

The HSE complaints policy was in place. A local policy was approved in August 2008, though no dates for implementation or review were included. Details were provided in the information booklet for residents. The complaints procedure was displayed in Our Lady's Ward.

**Compliant:** Yes

### **Article 32: Risk Management Procedures**

---

Risk management policies remained in draft form at the time of the inspection.

The approved centre's policy on absence without leave was approved in August 2008. No dates for implementation or review were included.

**Breach:** Article 32 (1) and Article 32 (2)

**Compliant:** No

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

### SECLUSION

---

Seclusion was not used in any part of the approved centre, though the seclusion policy did not reflect the fact that seclusion was not used. The service was asked to submit a statement to this effect but this was not provided.

**Breach:** Section 9.1 (a)

**Compliant:** No

### ECT

---

The approved centre complied with the Rules apart from the fact that there was no tipping trolley. The beds in the ECT suite were basic and did not contain a hard board, necessary for resuscitation. Requests had been made for a tipping trolley but the response given was lack of finance. This was despite an indication from the Local Health Manager in the implementation plan in January 2008 that the tipping trolleys were on order. The ECT policy was approved in August 2008. No review or implementation dates were included.

**Breach:** Section 10.3

**Compliant:** No

### MECHANICAL RESTRAINT

---

Mechanical restraint was not used in the centre and the service was requested to provide a statement to this effect and this was not provided

SECTION	DESCRIPTION	COMPLIANCE REPORT
21	<b>Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour</b>	Mechanical means of bodily restraint for enduring self-harming behaviour was not used in Our Lady's Ward. Part 5 was used on Unit 19 and Unit 21.

**Breach:** In the charts reviewed, a number of orders for restraint were not documented [Section 21.4]. A statement or policy in relation to the use of mechanical restraint was not provided [Section 18.1(a)].

**Compliant:** No

## 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	Physical restraint was recorded in the resident's file and in the clinical practice forms, which were available.
6	Clinical governance	There was a policy on physical restraint.
7	Staff training	Training of staff in control and restraint techniques was inadequate, though a significant number of staff still required training.
8	Child residents	There was no record of any child being restrained.

**Breach:** Section 7.1(e)

**Compliant:** No

### ADMISSION OF CHILDREN

---

Children had been admitted to the admission unit since November 2006. All children were automatically nursed on a one-to-one observation level. However the approved centre did not meet the Code of Practice on admission of children to approved centres.

**Breach:** Section 2

**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	<b>Notification of deaths</b>	All deaths were notified to the Mental Health Commission.
3	<b>Incident reporting</b>	All incidents were recorded and the records kept centrally. There were regular reviews of risks.
4	<b>Clinical governance</b>	There was a policy on risk management and there was a risk management committee.

**Compliant:** Yes

## ECT FOR VOLUNTARY PATIENTS

---

The approved centre complied with the Rules apart from the fact that there was no tipping trolley. The beds in the ECT suite were basic and did not contain a hard board, necessary for resuscitation. Requests had been made for a tipping trolley but the response given was lack of finance. The ECT policy was approved in August 2008. No review or implementation dates were included.

**Breach:** Section 9.3

**Compliant:** No

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

Section 61 was not applicable as all children had been admitted voluntarily. There were no detained patients in the continuing care and rehabilitation units. None of the detained patients had been admitted longer than three months.

**Compliant:** Not applicable