Report of the Inspector of Mental Health Services 2008

HSE AREA	HSE Dublin Mid-Leinster
CATCHMENT	Laois/Offaly
MENTAL HEALTH SERVICE	Laois/Offaly
APPROVED CENTRE	Department of Psychiatry, Midland Regional Hospital, Portlaoise
NUMBER OF UNITS OR WARDS	3
UNITS OR WARDS INSPECTED	Male Admission Female Admission Psychiatry of Later Life
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	49
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	22 September 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, Midland Regional Hospital, Portlaoise was an approved centre under the Mental Health Act 2001. The unit consisted of three wards with a total of 49 beds. Three sector teams, a psychiatry of later life team, and an intellectual disabilities and rehabilitation team had admitting rights to the unit.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Male Admission	23	20	3 sector teams Rehabilitation
Female Admission	17	19	3 sector teams Rehabilitation
Psychiatry of Later Life	6	4	Psychiatry of Later Life

The unit had 14 children admitted during the year to date. All wards were inspected and the Male Admission Ward was inspected in detail.

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. The approved centre should develop individual care plans as described in the Regulations.

Outcome: The service did not have individual care plans. There were detailed medical plans and nursing care plans. Referrals were made to other disciplines.

2. Staff from the recovery programme area should attend the MDT meetings.

Outcome: It was reported that staff attended the multidisciplinary team (MDT) meetings but this did always seem to be the case. The Inspectorate was told that weekly interventions were written in the case file and staff attended as required.

3. The assisted bathroom area where there was poor ventilation should be repaired, cleaned and repainted.

Outcome: This work had been completed.

4. The occupational therapy input to the unit should be restored.

Outcome: The occupational therapist was on leave and had not been replaced. The unit could access community occupational therapists for assessments if required.

5. The approved centre should monitor the impact, on patients and department functioning, of holding mental health tribunals away from the main campus.

Outcome: Tribunals occurred in another approved centre a short distance away. If the patient was too unwell to travel to the other approved centre the tribunal could be facilitated in the unit.

MDT CARE PLANS 2008

There was no overarching care plan. The service had detailed medical and nursing plans and there were integrated files. The standard of documentation by the NCHD and nursing staff was good. Referrals were made to other disciplines and their interventions were recorded in the case file but not in MDT care plans. The MDT meetings were held in the community facilities and the Inspectorate was informed by ward staff that they did not attend these meetings. Weekly ward rounds were held with nursing and medical staff. Each resident had a key nurse. All files inspected required re-organisation into defined sections. Many signatures were illegible.

GOOD PRACTICE DEVELOPMENTS 2008

- Quality service leaflets are in place for the residents to give feedback on the service.
- 2.5 whole-time-equivalent (WTE) consultant psychiatrists have been appointed to the service.
- Health & Safety meetings occur on a monthly basis.
- A number of local audits have been facilitated to govern clinical practice.
- Positive links with the rest of the hospital have been maintained.
- A training package on mental health issues was rolled out to members of An Garda Síochána.
- Training in assessment tools had been rolled out to the nursing staff.

SERVICE USER INTERVIEWS

None of the residents asked to speak with the Inspectorate.

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

1. MDT care plans must be introduced in line with Article 15 of the Regulations.

2. Ward-based staff should attend the MDT review meetings.

3. The therapeutic programme should be linked to individual care plans.

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 22 SEPTEMBER 2008

Article 12 (1-4): Communication

The service had a policy and was compliant with this Article.

Compliant: Yes

Article 13: Searches

The service had appropriate policies and was compliant with this Article.

Compliant: Yes

Article 15: Individual Care Plan

Individual care plans were not in use. Separate nursing and occupational therapy care plans were up to date and reviewed regularly.

Breach: Individual care plans were not in use.

Compliant: No

Article 16: Therapeutic Services and Programmes

Referral to psychology, social work and occupational therapy was available. There was also a recovery programme that involved individual assessment. The programme was delivered by nursing staff. The occupational therapist based on the unit was on maternity leave and had not been replaced.

Breach: Article 16 (1) Therapeutic activities were not linked to individual care plans.

Compliant: No

Article 17: Children's Education

Education was available to children and needs were assessed on an individual basis. Recently Leaving Certificate exams were facilitated on the unit.

Compliant: Yes

Article 18: Transfer of Residents

The service had a policy and was compliant with this Article.

Compliant: Yes

Article 19 (1-2): General Health

The service was compliant with this Article.

Compliant: Yes

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

A noticeboard on the corridor displayed information about the residents' MDTs and meal times. An information leaflet outlined meal times, visiting arrangements, personal property arrangements and included details of advocacy and voluntary agencies. Information about common psychiatric diagnoses and medications, including side effects, was available on the unit. The Irish Advocacy Network attended the unit weekly. The centre had a policy with the title *Provision of Information to Residents*.

Compliant: Yes

Article 21: Privacy

The service was compliant with this Article.

Compliant: Yes

Article 25: Use of Closed Circuit Television (CCTV)

CCTV was used on the unit. The signs indicating the use of CCTV were now prominently displayed. The system was not capable of recording.

Compliant: Yes

Article 26: Staffing

The HSE policies in relation to the recruitment, selection and vetting of staff applied to this centre. It was reported that the skill mix of staff was appropriate to meet the assessed needs of the residents. However in the absence of MDT care planning it was difficult to quantify if the needs of the residents were being met. Currently there was no occupational therapist based on the unit.

Staff reported that they had access to further training and education and a number of them had completed training courses. Staff reported that they had received training in the Mental Health Act 2001, and copies of the Act, Regulations, Rules and Codes of Practice were available on the unit.

Breach: The skill mix of the staff was not appropriate to meet the assessed needs of the residents [Article 26 (2)].

Compliant: No

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

SECLUSION

The Male Admissions Unit had two seclusion rooms on the ward and no one was in seclusion on the day of the inspection. The Female Admissions Unit had one seclusion room on the ward and no one was in seclusion on the day of the inspection. A file of a patient who had been secluded was reviewed. The file was in order and contained the orders for seclusion and nursing observations. The seclusion register was reviewed and was found to be in order. The centre had a policy on seclusion issued in May 2007.

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	**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**	Compliant
10	**Staff training**	Compliant
11	**CCTV**	Compliant
12	**Child patients**	Not applicable

Compliant: Yes

ECT

No detained patient underwent ECT.

Compliant: Not applicable

MECHANICAL RESTRAINT

The Inspectorate was informed that mechanical restraint was not used in the unit. Staff also reported that mechanical restraint for enduring self-harm behaviour was not used.

Compliant: Not applicable

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

PHYSICAL RESTRAINT

The physical restraint clinical practice forms on the Male Admissions Unit were inspected and 17 orders for physical restraint were found to have been recorded. Each restraint was well documented according to the MHC Code of Practice. A policy on the Use of Physical Restraint was issued in May 2007.

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**	Compliant
8	**Child residents**	Compliant

Compliant: Yes

ADMISSION OF CHILDREN

The service had a policy on the admission of children. Fourteen children had been admitted to the unit during the year. All were voluntary and within the 16 to 18 age range.

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**	Compliant. Consent procedures were in place for admission and assessment.
3	**Treatment**	Compliant. Children were admitted with a single room and were always on special nursing observation regardless of assessed need.
4	**Leave provisions**	Compliant. Provided as required.

Compliant: Yes

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

There were two notifications of death reported in 2008. Both notifications met the MHC Code of Practice requirements. 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

The ECT suite was located on the unit and had a waiting area with two changing rooms, a treatment room and a recovery room. ECT was administered on Mondays and Thursdays and there was a dedicated ECT consultant and nurse. There was a dedicated anaesthetist who attended from the general hospital. The ECT register with six episodes of ECT administered this year was reviewed. The Rules on prescription of ECT were incomplete. Six patient's files were reviewed and although each record had a completed consent to anaesthesia there was one file with no record of a patient assessment by the anaesthetist. All patients had specified blood tests, ECG and chest X-ray prior to treatment. An ECT information leaflet was available to residents. 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**	Non-compliant
5	**Assessment of voluntary patient**	Non-compliant
6	**Anaesthesia**	Compliant
7	**Administration of ECT**	Compliant
8	**ECT Suite**	Compliant
9	**Materials and equipment**	Compliant
10	**Staffing**	Compliant
11	**Documentation**	Non-compliant
12	**ECT during pregnancy**	Not applicable

Breach: The sections on prescription of ECT, patient assessment for ECT, and documentation relating to ECT were not completed as defined in the Code of Practice.

Compliant: No

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

There was only one detained resident and all was in order with their detention.

Compliant: Yes