

Report of the Inspector of Mental Health Services 2008

HSE AREA	HSE West
CATCHMENT	Roscommon
MENTAL HEALTH SERVICE	Roscommon
APPROVED CENTRE	Department of Psychiatry, County Hospital, Roscommon
NUMBER OF UNITS OR WARDS	1
UNITS OR WARDS INSPECTED	Department of Psychiatry
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	30
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	4 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

Roscommon, with a population of less than 60,000, has three general adult teams, each with a small population. There was an in-patient unit based in the south of the county that is rarely full. There was one 7-day day hospital in operation. On the day of the inspection, there were 19 residents in the approved centre, one voluntary patient was on leave, and two detained patients were on long-term leave to a 24-hour-supervised community residence. Their records were not on site and were requested and received from the community residences for review.

Since the last inspection, the ECT suite had been decommissioned and a high observation area was at an advanced stage of completion. The bathrooms and toilet areas had been renovated to a high standard. The services were developing a private bed room with bathroom facilities for children aged 16-18 years.

The ward had a high staff-to-patient ratio, no pressure on beds and time available for direct patient contact.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Department of Psychiatry	30	22	General adult team

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. *Each resident should have a MDT care plan.*

Outcome: A system was introduced in November 2007. On reviewing the notes and speaking with staff the system was not operating as planned. The responsibility of writing the care plans was unclear.

2. *The multidisciplinary care plans should be linked to the therapeutic programme.*

Outcome: The activity/recreation programme was delivered in the main by the occupational therapy assistant. There was a 0.5 whole-time-equivalent basic grade occupational therapist available. A clinical nurse specialist (CNS) facilitated education on medication. Neither programme was linked to an individual care plan. There was no evidence that other disciplines contributed to the programme.

3. *Policies, procedures and protocols should be in place that meets the requirements of the Regulations, Rules and Codes of Practice issued by the Mental Health Commission.*

Outcome: The service had submitted all the policies prior to the inspection.

4. *The high observation area should be developed.*

Outcome: The three-bed high observation area was at an advanced stage of completion. It was due to be completed at the end of September. The area will also include a sitting and dining area, an office and the original seclusion room.

5. *The community mental health teams should be adequately resourced with all disciplines.*

Outcome: No additional staffing was provided to the teams. No speciality teams had been appointed. It was reported that the hours provided by the clinical psychologist had been reduced to provide a service elsewhere. It was reported in writing, following the inspection, that issues around teams not being fully resourced related to the embargo on hiring staff.

MDT CARE PLANS 2008

The service had developed multidisciplinary team care plans and introduced them in November 2007. They were not being applied to an acceptable standard. It was clear that all members of the teams were not contributing to the team meetings and the service users were not receiving a care plan based on individualised assessed needs. It was reported that there was a difficulty scheduling team meetings to accommodate all disciplines. There was a single file subdivided into section by discipline. In the notes reviewed there were entries from the nursing medical and occupational therapy assistant staff. There was no evidence that other disciplines contributed to the care plan.

GOOD PRACTICE DEVELOPMENTS 2008

- The ECT suite had been decommissioned, after going out of use in 2005. Residents requiring ECT treatment were transferred to East Galway.
- The patient information booklet had been updated.

SERVICE USER INTERVIEWS

All service users were offered the opportunity to speak to the Inspectorate team individually but they all declined. A number of service users spoke informally 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. The system developed must be reviewed and all disciplines must be responsible for meeting the requirements of Article 15.
2. The care plans should be linked to the therapeutic activity and educational programme.
3. All disciplines must record entries in the charts.
4. Policies and procedures must be developed and implemented for the opening of the high observation area.
5. There must be regular audit of documentation standards and implementation of the Rules, Codes of Practice and Regulations under the Mental Health Act 2001.
6. There must be a sufficient number of health and social care professionals in place to meet the assessed needs of the residents.

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 4 SEPTEMBER 2008

Article 6 (1-2) Food Safety

A copy of the Senior Environmental Health Officer's report for Roscommon County Hospital dated 14 March was submitted. There were no recommendations for the Department of Psychiatry.

Compliant: Yes

Article 7: Clothing

The service had submitted a policy and procedure. A number of charts were reviewed, not all residents' in night clothes had this documented in their care plan.

Breach: Each resident in night clothes must have this documented in their care plan.

Compliant: No

Article 8: Residents' Personal Property and Possessions

The service was compliant.

Compliant: Yes

Article 11 (1-6): Visits

The unit had open visiting times, but visitors were asked to avoid meal times. The unit had a policy on visiting.

Compliant: Yes

Article 12 (1-4): Communication

Public phones were available for residents on the unit. Residents could use their own mobile phones according to the local policy. The unit had a policy on communication.

Compliant: Yes

Article 13: Searches

The service had a policy and procedure in place. No search records were reviewed during the inspection.

Compliant: Yes

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

The service had a policy and procedure in place that complied with the Article.

Compliant: Yes

Article 15: Individual Care Plan

Residents did not have individual care plans based on assessed needs. A number of files had blank multidisciplinary care plans, others were incomplete. Photographic evidence was taken. In the absence of this system operating, nursing staff completed nursing care plans and there were medical plans in the files.

Breach: Each resident did not have an individual care plan as defined in Article 15.

Compliant: No

Article 16: Therapeutic Services and Programmes

There were two programmes in operation. The occupational therapy programme was delivered by an occupational therapy assistant over five days. A 0.5 whole-time-equivalent basic grade occupational therapist attended the ward for team meetings and individual work. The programme was limited and was not linked to the individualised needs of the residents.

A number of complementary therapists also attended. Education on medication was facilitated by a CNS. A copy of the programme was requested but not received. There was no evidence that other disciplines contributed to the programme. The clinical psychology hours had been reduced by one day since the last inspection.

Breach: The programme was not linked to individual care plans.

Compliant: No

Article 17: Children's Education

The service had a policy and procedure in place regarding the provision of children's education, based on need.

Compliant: Yes

Article 18: Transfer of Residents

The service had a policy and procedure in place.

Compliant: Yes

Article 19 (1-2): General Health

The unit was based in a general hospital and had access to the services available on site. National screening programmes appointments were facilitated. There were three residents in the approved centre for greater than six months. None of them had received a six monthly physical examination. Other files were reviewed; where physical examinations had been completed, the standard of recording was poor and often had no date or residents names in place.

Breach: Not all residents had six-monthly physical examinations.

Compliant: No

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

The service had a policy and procedure in place. A new information booklet had been developed and introduced. It was reported that a CNS was available to provide information to residents on medication. A copy of this programme was requested but not received by the inspectorate team. An advocate attended the ward weekly.

Breach: There was no evidence provided that residents received information on medications.

Compliant: No

Article 21: Privacy

The service was compliant.

Compliant: Yes

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

The service had submitted a policy and procedure in compliance with this Article.

Compliant: Yes

Article 25: Use of Closed Circuit Television (CCTV)

CCTV was not used on the unit.

Compliant: Not applicable

Article 26: Staffing

All staff were recruited through the central HSE procedure. The unit had 28 nurses employed. A CNM2 was on duty at all times, and there were 5.0 whole-time-equivalent posts. In addition there was a CNM3 based on the unit, a CNS and an occupational therapy assistant. Three general adult sector teams provided input, but not all disciplines were represented on these teams. It was reported in writing that issues around teams not being fully resourced related to the embargo on hiring staff.

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

STAFF TYPE	DAY	NIGHT
Nursing	5	4
CNM2	1	1
CNM3	1	N/A
CNS	1	N/A
Occupational Therapy Assistant	1	N/A
Basic Grade Occupational Therapist	2.5 days per week	N/A

Mandatory training in cardio-pulmonary resuscitation (CPR), manual handling and physical restraint techniques had been stopped. Staff had received training on the Mental Health Act 2001. A copy of the Act, Regulations, Rules and Codes of Practice were kept on the unit and available to all staff.

Breach: Mandatory training had stopped. The teams had insufficient staffing of health and social care professionals.

Compliant: No

Article 27: Maintenance of Records

Current case notes of residents were kept on the unit. Each resident had a single set of notes that all disciplines could access and where they could record their interventions. All were stored in the ward office. The HSE policy applied in relation to the creation and destruction of and the retention of records. Records of food safety audits, health and safety checks and fire inspections were made available to the Inspectorate.

Compliant: Yes

Article 28: Register of Residents

Each resident detail (Schedule 1) was placed in each file.

Compliant: Yes

Article 29: Operating policies and procedures

The policies and procedures were reviewed by all disciplines, coordinated by the CNM3.

Compliant: Yes

Article 31: Complaint Procedures

A complaints officer was not in post at the time of inspection. Internally complaints were sent to the assistant director of nursing who investigated or passed them on to the director of nursing. A policy was made available to the Inspectorate. Service users also had access to the HSE national complaints service. Information leaflets were available on the unit.

Compliant: Yes

Article 32: Risk Management Procedures

The service did not have a comprehensive risk management policy in place. In its absence, the service had a procedure in place for recording and reporting incidents. There was a written policy in place for responding to a resident being absent without leave. There was no procedure in place for responding to a suicide or self harm. All incidents were recorded and six-monthly reports were sent to the Mental Health Commission. There was no formal system in place for reviewing incidents saying who should be involved. An assessment of risks throughout the unit had been completed in the past. A copy of this report was requested but not sent to the Inspectorate team.

Breach: The service did not have a comprehensive written risk management policy in place that met the requirements of the Article.

Compliant: No

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

SECLUSION

The seclusion room was located in the high observation area. On the day of the inspection it was not in use as there were building works in progress. CCTV was not used. The seclusion facilities were of a good standard. A seclusion policy outlined the frequency of observation and review of the resident in seclusion. A number of files were cross-referenced with the seclusion register.

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	The orders were not completed in accordance with the rules. There was no record that the patient had been informed or a reason why this information was not given. Photographic evidence was taken.
3	Patients' dignity and safety	Compliant
4	Monitoring of the patient	In one of the files reviewed the patient was reviewed every eight hours instead of every four hours.
5	Renewal of seclusion orders	Not applicable
6	Ending seclusion	This was not recorded in the register.
7	Facilities	Compliant
8	Recording	The register was incomplete. A number of entries were not signed by the consultant psychiatrist. Photographic evidence was taken.
9	Clinical governance	Compliant
10	Staff training	It was reported that mandatory training was not being currently funded by the HSE. Information regarding the number of staff that requires training must be provided.
11	CCTV	Not applicable
12	Child patients	Not applicable

Breach: Seclusion was not recorded in accordance with the Rules and training was not being provided.

Compliant: No

ECT

The ECT suite had been decommissioned since the last inspection.

Compliant: Not applicable

MECHANICAL RESTRAINT

Staff reported that mechanical restraint was used on the unit recently. The register was reviewed. The patient had been discharged so that chart was not cross-referenced.

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

SECTION	DESCRIPTION	COMPLIANCE REPORT
14	Orders	Not reviewed. Clinical file not available.
15	Patient dignity and safety	Compliant
16	Ending mechanical restraint	Compliant
17	Recording use of mechanical restraint	Not reviewed. Clinical file not available.
18	Clinical governance	A draft policy was available. It did not contain reference to Part 5 of the Rules.
19	Staff training	It was reported that mandatory training was not been currently funded by the HSE. Information regarding the number of staff that requires training was requested but not provided.
20	Child patients	Not applicable
21	Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour	Staff reported that mechanical restraint for enduring self-harm behaviour was not used on the unit.

Breach: The service must have a policy in place and provide regular training to staff.

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	The register was unsigned. Photographic evidence was taken.
6	Clinical governance	It was reported that an annual report had been completed and sent to the MHC Standards and Quality Assurance Division. The policy was in place and updated to include a yearly review.
7	Staff training	It was reported that mandatory training was not been currently funded by the HSE. Information regarding the number of staff that requires training was requested but not provided.
8	Child residents	Not applicable

Breach: The documentation was not completed in compliance with the code of practice. Training had been stopped.

Compliant: No

ADMISSION OF CHILDREN

One voluntary child had been admitted to the unit overnight this year. The service had a policy and procedures on the admission of children. The services are to convert a single room into a bedroom with bathroom facilities for children aged 16–18 years. It was reported that building works would commence soon.

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	The centre was unable to provide for sections of Section 2.5, in relation to age-appropriate activities, age-appropriate advocacy services and risk assessments. There were no policies on parental consent, family liaison and confidentiality.
3	Treatment	Not applicable
4	Leave provisions	Not applicable

Breach: The centre did not comply with Section 2.5 of the Code of Practice Relating to the Admission of Children.

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	All deaths were reported to the Mental Health Commission.
3	Incident reporting	Incidents were recorded and reported as per local procedure. The service was non-compliant with Article 32.
4	Clinical governance	There was no written risk management policy and procedure in place.

Breach: There was no written risk management policy and procedure in place.

Compliant: No

ECT FOR VOLUNTARY PATIENTS

The ECT suite had been decommissioned since the last inspection.

Compliant: Not applicable

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

There was no adult or child on the unit that met the requirements of these Sections of the Act.

Compliant: Not applicable