

Report of the Inspector of Mental Health Services 2008

HSE AREA	HSE South
CATCHMENT	Carlow Kilkenny
MENTAL HEALTH SERVICE	Carlow Kilkenny
APPROVED CENTRE	Department of Psychiatry, St Luke's Hospital, Kilkenny
NUMBER OF UNITS OR WARDS	2
UNITS OR WARDS INSPECTED	Acute Sub-acute
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	44
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	5 June 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, the CNM2s on the units, the hospital administrator, director of nursing, assistant director of nursing, the heads of social work and occupational therapy and a clinical psychologist. One service user agreed to meet with the Inspectorate.

DESCRIPTION

The Department of Psychiatry was located in the grounds of the general hospital in Kilkenny. It was a modern purpose-built premises, divided into acute and sub-acute units. Up to five sector teams, the psychiatry of later life team and the rehabilitation team could admit people to the units.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Acute	19	19	Up to 7 teams
Sub-acute	25	21	Up to 7 teams

The Inspectorate commended the service for the commitment and hard work demonstrated by full implementation of all of the recommendations from last year's Report and by completion or making substantial progress on the actions identified in the implementation plan submitted to the MHC Standards and Quality Assurance Division to address breaches in compliance identified during last year's inspection. The Inspectorate noted the ethos of continuous quality improvement and multidisciplinary team working at different levels within the service that was evident in the numerous ongoing audits and service developments within the approved centre. Staff in the Department of Psychiatry were enthusiastic about the introduction of the new

multidisciplinary care plans. In general, they reported that the new care plans had resulted in more involvement of the disciplines in the care planning process, despite the limited numbers of health and social care professionals, and more active involvement of residents in contributing to their own care and treatment.

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. The approved centre must have individual care plans as defined in the Regulations. The Inspectorate suggested to the senior management team that this could be progressed by a MDT working group that would facilitate the involvement of all disciplines in the roll-out of this requirement. Since the inspection, a working group had been established to progress this.

Outcome: The working group produced a MDT care plan that was being piloted in the Department of Psychiatry. The pilot started in mid-April and was due to be audited after three months. The residents and staff were to be surveyed as part of the audit. It was reported that all teams were using the care plan and that it was going well. The limited numbers of health and social care professionals in the service resulted in sharing of these posts across teams and this was proving to be a problem.

2. The registers for seclusion and restraint must be completed in full, originals filed in clinical files, copies left in the register and the relevant records entered in the clinical file. The draft policies on physical restraint refer to seclusion and mechanical restraint and need to be amended.

Outcome: The registers were completed and policies were in place.

3. Physical reviews of general health must be completed as required, or at least not less often than every six months. Following the inspection visit, the service reported that a template had been devised and introduced to monitor each individual to ensure that they receive a physical examination/mental health assessment every six months. This template also monitors breast checks, cervical smears, and prostate-specific antigen (PSA) tests annually.

Outcome: This recommendation was met.

4. Direct access to enclosed garden from both units should be considered.

Outcome: Each ward now had direct access to an enclosed garden. The sub-acute ward had a new garden which was a positive addition.

5. The signage for CCTV must be more prominent, specifically around the seclusion room. Following the inspection visit the service reported that this had been done.

Outcome: This recommendation was met.

6. ECT Rules must be complied with as specified below. In particular, consent to anaesthesia must be documented by the anaesthetist. Following the inspection visit, the service reported that issues regarding the consent form had been addressed.

Outcome: All of the recommendations in relation to ECT were met.

7. A systematised approach to risk assessment should be implemented, leading to risk management plans. Following the inspection, the service reported that a clinical governance group had been established to meet every three months with the Clinical Risk Manager to review incidents.

Outcome: An adverse incidents review group had been established and this reviewed all clinical incidents. The service planned to implement a risk assessment tool in July 2008.

8. The approved centre must have policies relating to the admission of children. Following the inspection, the service reported that the requirement of an admissions policy for children, pending the provision of interim dedicated beds in St. Stephen's Hospital, Cork, had been referred to the local policy group for consideration.

Outcome: A policy was in place.

MDT CARE PLANS 2008

A multidisciplinary working group had devised an individual care plan booklet which had been implemented in the Department of Psychiatry. Initial care plans were based on standard nursing assessments and medical and psychiatric assessments only. The front page of the care plan contained a summary of the resident's presentation and risk factors at admission as well as the resident's view of their problem or situation. The second page had a section for identification of specific goals and needs, the action required to ameliorate each need and the person responsible for progressing the action. There was also a section for the resident to sign each need and action, as well as a separate section to record the resident's views over time. The back page contained details of the resident's multidisciplinary team and a section to record the date and attendance at team meetings.

Team meetings took place every week, some on the unit and some at the sector team headquarters because of the geographical distance of the team from the unit. Where meetings took place off in the sector headquarters, one of the nursing staff from the unit usually attended and brought the relevant clinical file for review. From time to time, there were logistical problems with achieving this and reviews had to take place in the absence of access to the clinical notes and care plans. None of the teams had a full complement of health and social care professionals due to funding constraints. Health and social care professionals were shared across the general adult and speciality team. This limited their capacity to contribute input to care plans and it had been difficult for professionals to build up specialist skills when shared across specialty and general adult services.

GOOD PRACTICE DEVELOPMENTS 2008

- Individual care plans had been introduced with a plan for review and audit after three months.
- The establishment of the clinical governance and adverse incident groups.
- The ORCHID project, which provided information to residents on a number of mental health issues.
- Family consultation with all new admissions across all sectors.
- A new drug card index system had been introduced.
- A protocol for physical examinations had been implemented.
- An audit of discharge summaries had been undertaken.

SERVICE USER INTERVIEWS

One resident asked to meet with the Inspectorate. She was generally satisfied with her care and treatment. She felt involved in her care and knew her team. Her main concerns were that there was little to do in the evenings and the evening meal was too early.

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

1. The agreed clinical risk management tool should be implemented following training for all clinical staff.
2. The approved centre should continue to develop the MDT care plans, initially by audit and review of the pilot phase, and in the future by developing comprehensive initial assessments of residents' needs.
3. A copy of the back page of the care plan, which contains the details of the resident's multidisciplinary team, could be provided to residents to enhance the information made available to them.
4. Consideration should be given to unit self-staffing throughout the service to enhance the quality of care and treatment to residents by allowing nurses to specialise in particular areas.
5. Funding should be made available to ensure that teams have a full complement of core multidisciplinary team members, to enhance the quality of care and treatment to residents by allowing team members to specialise in particular areas.

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 5 JUNE 2008

Article 15: Individual Care Plan

A new multidisciplinary team care plan had been implemented.

Compliant: Yes

Article 16: Therapeutic Services and Programmes

Residents had access to a range of therapeutic services and programmes provided by clinical nurse specialists and an occupational therapist based on the unit, and by clinical psychologists and social workers from their sector teams. These activities were linked to the resident's care plan.

Compliant: Yes

Article 17: Children's Education

Generally admissions of children had been of short duration and education had not been required as determined by individual needs assessment.

Compliant: Yes

Article 18: Transfer of Residents

The Department of Psychiatry used different forms for transmitting relevant information depending on the needs of the resident. Policies and procedures were in place for transfers of residents to other approved centres, general hospitals and the Central Mental Hospital.

Compliant: Yes

Article 19 (1-2): General Health

All six-monthly physical examinations had been carried out and there was a system in place to highlight when residents were due their next examination. There was good access to medical specialties in the general hospital and residents were seen in the Department of Psychiatry if required.

Compliant: Yes

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

A social work led multidisciplinary and interagency working group had developed ORCHID, an electronic system containing information related to mental health including information on diagnosis, medication, voluntary groups, self-help interventions and other related resources. A FÁS worker was available regularly to help residents access the information and to update the system.

Compliant: Yes

Article 21: Privacy

The unit was compliant.

Compliant: Yes

Article 26: Staffing

Staff had completed training on the Mental Health Act. In addition to the rostered nursing staff, the CNS and occupational therapist based on the unit, psychiatrists, clinical psychologists and social workers from the multidisciplinary teams provided therapeutic services to the residents from their sector. There were shared health and social care professionals on all the sector teams which limited their capacity to provide services, none of the teams had a full complement of clinical psychologists, social workers or occupational therapists. The specialist psychiatry of later life and rehabilitation teams had no dedicated clinical psychologists, social workers or occupational therapists, apart from the occupational therapist dedicated to the psychiatry of later life team. It was difficult for professionals to build up specialist skills when shared across specialty and general adult services.

Compliant: Yes

Article 27: Maintenance of Records

The Department of Psychiatry had a policy on access to and creation, maintenance, storage and destruction of records. The Inspectorate was informed that records were not destroyed. The policy should be reviewed to ensure it reflects local procedure.

Compliant: Yes

Article 32: Risk Management Procedures

A clinical risk assessment tool was due to be implemented in July 2008. The approved centre reported that in order to comply with this Article, individual risk management policies were due to be reviewed and collated under an umbrella policy document by mid-October 2008. An adverse incident review group had been established and it was planned that this group would feed into the clinical governance group monthly.

Breach: The approved centre did not have a comprehensive risk management policy in place [Article 32 (1)]. Arrangements for the identification; recording, investigation and learning from adverse events were not yet in place [Article 32 (2)(d)].

Compliant: No

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

SECLUSION

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	Compliant
8	Recording	Compliant
9	Clinical governance	Compliant
10	Staff training	Non-compliant
11	CCTV	Compliant
12	Child patients	Compliant

Breach: Staff were not receiving training or refresher courses in restraint [Section 10].

Compliant: No

ECT

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	Compliant
3	Information	Compliant
4	Absence of consent	Compliant
5	Prescription of ECT	Compliant
6	Patient assessment	Compliant
7	Anaesthesia	Compliant
8	Administration of ECT	Compliant
9	ECT Suite	Compliant
10	Materials and equipment	Compliant
11	Staffing	Compliant
12	Documentation	Compliant
13	ECT during pregnancy	Compliant

Compliant: Yes

MECHANICAL RESTRAINT

Mechanical restraint was not used and the service had a policy stating this.

SECTION	DESCRIPTION	COMPLIANCE REPORT
21	Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour	This was not in use on the day of inspection

Compliant: Not applicable

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

PHYSICAL RESTRAINT

A checklist had been devised to ensure that the documentation required was completed. Staff were not receiving ongoing training or refresher courses in restraint techniques. 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 (see above)
8	Child residents	Compliant

Breach: Staff were not receiving ongoing training or refresher courses in restraint techniques [Section 7].

Compliant: No

ADMISSION OF CHILDREN

The Department of Psychiatry had a policy in relation to 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.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	Admission	Non-compliant. There were no policies or procedures with regard to family liaison
3	Treatment	Compliant
4	Leave provisions	Compliant

Breach: There were no policies or procedures with regard to family liaison [Section 2.5(l)].

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
4	Clinical governance	Non-compliant

Following the inspection, the approved centre reported plans to ensure compliance with Section 3 and Section 4 by mid-October (see Article 32 report above).

Breach: Identification, recording, investigation and learning from adverse events were not yet in place [Section 3]. There was no comprehensive risk management policy that met Section 4.

Compliant: No

ECT FOR VOLUNTARY PATIENTS

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)**

The clinical files reviewed contained written consent forms signed by patients for the continued administration of medication.

Compliant: Yes