

Report of the Inspector of Mental Health Services 2008

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| HSE AREA | HSE South |
| CATCHMENT | Waterford |
| MENTAL HEALTH SERVICE | Waterford |
| APPROVED CENTRE | Department of Psychiatry, Waterford Regional Hospital |
| NUMBER OF UNITS OR WARDS | 1 |
| UNITS OR WARDS INSPECTED | Department of Psychiatry |
| NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED | 44 |
| CONDITIONS ATTACHED TO REGISTRATION | No |
| TYPE OF INSPECTION | Unannounced |
| DATE OF INSPECTION | 19 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.

DESCRIPTION

The Department of Psychiatry is located in Waterford Regional Hospital. It has 44 beds and is divided into a 10-bed acute area, which is locked, and a 34-bed subacute area, which is open. Five community mental health teams admit to the unit as well as the psychiatry of later life team. The service is lacking any occupational input which causes serious deficits in the area of assessment and therapeutic activities for service users. The Department of Psychiatry had serious difficulties in meeting the requirements of the Regulations for Approved Centres in 2007, including the introduction of an integrated care plan.

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. Individual care plans should be introduced in line with the requirements of the Regulations.

Outcome: This had not been achieved. However a draft proposal was under consideration.

2. Policies should be updated to be compliant with the Regulations and Rules.

Outcome: This has been achieved.

3. The composition of the sector teams should be enhanced with the necessary multidisciplinary input in order to expedite the policies outlined by the Government in A Vision for Change.

Outcome: No addition in staffing to community mental health teams had taken place.

4. A risk assessment should be completed regarding access to the garden for residents.

Outcome: There continued to be no access for service users to the garden due to lack of privacy.

MDT CARE PLANS 2008

There was no individual care plan with multidisciplinary input available. The service was in the process of introducing an integrated clinical file. Nursing care plans continued to be kept separately. The service was in the process of developing a multidisciplinary care plan but further work on the format was required in order for it to meet the requirements of the Regulations. It was evident that training for staff in the use of multidisciplinary care planning was required.

Regular team meetings were held on the ward and individual recording of outcomes was made in each clinical file. There was low multidisciplinary staffing on sector teams, which would impact on multidisciplinary care planning when it is introduced.

GOOD PRACTICE DEVELOPMENTS 2008

- A new medication sheet was due to be introduced within a few weeks.

SERVICE USER INTERVIEWS

All service users who spoke with the Inspectorate were happy with their care.

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

1. The Department of Psychiatry should introduce an integrated care plan.
2. There is an urgent requirement for an occupational therapy service to provide assessments and therapeutic activities.
3. Training in multidisciplinary care planning should be provided for all staff.

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 19 JUNE 2008

Article 6 (1-2) Food Safety

The service was compliant with this Article.

Compliant: Yes

Article 7: Clothing

Residents had their own supply of clothing. If a resident required clothing there was a small bank of clothing held on the unit, or clothing could be accessed from St. Otteran's Hospital. There was documentation in residents' clinical files if night clothes were prescribed to be worn all day. There was a policy on personal clothing.

Compliant: Yes

Article 8: Residents' Personal Property and Possessions

A property sheet was completed for each resident on admission to the unit. Personal property and possessions were kept in the resident's wardrobe or locker at the bedside. Large sums of money were held in the central office. The unit had only a draft policy on personal property and possessions. A written operational policy was subsequently submitted to the Inspectorate.

Compliant: Yes

Article 11 (1-6): Visits

The unit had a flexible visiting policy. Children had to be accompanied by an adult relative at all times. There was no dedicated visiting area and the dining area was used. There was no area for residents to receive children visiting residents. The unit only had a draft policy and procedure for visits. A written operational policy was subsequently submitted to the Inspectorate.

Breach: Appropriate facilities for visiting were not available [Article 11 (5)].

Compliant: No

Article 12 (1-4): Communication

There was no restriction on communication, except in the acute area where residents were not allowed to retain mobile phones. The unit had only draft policies and procedures on communication. Written operational policies and procedures were subsequently submitted to the Inspectorate.

Compliant: Yes

Article 13: Searches

All staff were aware of the procedures on searching. However there were only draft policies on searching and on finding of illicit substances. A written operational policy was subsequently submitted to the Inspectorate.

Compliant: Yes

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

Any resident taken seriously physically ill was transferred to general wards in the hospital. The unit had only draft policies and procedures for care of residents who are dying. A written operational policy was subsequently submitted to the Inspectorate.

Compliant: Yes

Article 15: Individual Care Plan

The medical and nursing notes were maintained separately. Integrated clinical notes were ready to be implemented. The unit did not have individual integrated care plans as defined in the Regulations. There was evidence that these were being developed but an implementation date was not yet available. The draft care plan required significant further input in order for it to be compliant with this Article.

Breach: There was no individual care plan in place.

Compliant: No

Article 16: Therapeutic Services and Programmes

A nurse-run activities programme was available on the unit. Activities included relaxation, yoga music, discharge planning, meeting with the Irish Advocacy Network (IAN), yoga, art, aromatherapy and social activities. These activities were not linked to an individual care plan. There was no occupational therapy input to the unit apart from psychiatry of later life. In the absence of individual care plans as defined by the Regulations and in the absence of occupational therapists, there was no indication that this Article would be addressed in the near future.

Breach: Therapeutic activities were not linked to care plans.

Compliant: No

Article 17: Children's Education

The unit had no written operational policy on children's education. The service reported that they intended to address this. With the opening of dedicated child and adolescent beds in the region within the next 12 months, it was unclear as to the reason to continue to admit children to this unit and therefore the intention to provide education.

Compliant: Yes

Article 18: Transfer of Residents

In the case of transfers to St. Otteran's Hospital, the resident's clinical file and nursing care plan accompanies the resident. All staff were aware of procedures. Any resident transferred to outside agencies were accompanied by photocopies of their current treatment plan, the NCHD's referral letter and a completed nursing transfer form. There was only a draft policy on the transfer of residents. A written operational policy was subsequently submitted to the Inspectorate.

Compliant: Yes

Article 19 (1-2): General Health

The clinical files examined showed evidence that the general health needs of the residents were assessed regularly. There was only a draft policy on medical emergencies. A written operational policy was subsequently submitted to the Inspectorate.

Compliant: Yes

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

The information booklet was in the process of being updated and was close to completion. The new booklet gave details of housekeeping practices, meal times, visiting times and visiting arrangements and also gave details of the resident's multidisciplinary team and would meet the requirements of Article 20 (1) when introduced. Details of the Irish Advocacy Network (IAN) and the unit's advocate and contact number were displayed on the unit. Information on diagnosis and medications was available to the resident through their primary nurse and consultant psychiatrist or NCHD. The unit had only a draft policy on providing information to residents. A written operational policy was subsequently submitted to the Inspectorate.

Breach: The updated information leaflet had not been introduced [Article 20 (1)].

Compliant: No

Article 21: Privacy

The unit provided privacy in most areas, but the CCTV monitor in the acute area for the seclusion room was visible to residents and any visitors to the unit on the day of inspection. Subsequent correspondence from the service stated that this was being rectified.

Breach: The use of CCTV at the time of inspection breached the Article on privacy.

Compliant: No

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

The unit had only draft policies relating to the ordering, prescribing, storing, and administration of medicines to residents. Written operational policies that complied with this Article were subsequently submitted to the Inspectorate.

Compliant: Yes

Article 24 (1-2): Health and Safety

The unit had a current health and safety statement. The unit had only draft policies and procedures relating to the health and safety of residents, staff and visitors. Written operational policies and procedures were subsequently submitted to the Inspectorate.

Compliant: Yes

Article 25: Use of Closed Circuit Television (CCTV)

CCTV was used only in the acute area for observation of a resident in seclusion. The monitor on the nurses' desk was clearly visible to staff, residents and any visitors to the acute area. There were tentative plans to change the position. This situation was reported in 2007 and staff management were again informed of the breach of confidentiality and had subsequently addressed this.

Breach: The CCTV was used in such a way that it compromised the dignity of resident in seclusion [Article 25 (1)(e)].

Compliant: No

Article 26: Staffing

The HSE policy and procedures relating to the recruitment, selection and vetting of staff applied. Nursing staff were allocated to the unit by a central rostering system. Social work and psychology were insufficient to provide a service to each sector team. There was only one occupational therapist in the service, on the psychiatry of later life team. There was no input from occupational therapy into therapeutic activities. In-service training was ongoing but was affected by nursing staff shortages.

Breach: There were no occupational therapists available to the unit [Article 26 (2)].

Compliant: No

Article 27: Maintenance of Records

Some clinical files examined were untidy with loose sheets. The integrated chart was due to be introduced in the near future. The unit had only draft policies and procedures relating to the creation of, access to, and retention and destruction of records. Written operational policies and procedures were subsequently submitted to the Inspectorate.

Compliant: Yes

Article 28: Register of Residents

The register of residents was fully compliant with Schedule 1 of the Regulations.

Compliant: Yes

Article 29: Operating policies and procedures

Operating policies and procedures required under the Regulations, Rules and Codes of Practice were submitted to the Inspectorate.

Compliant: Yes

Article 31: Complaint Procedures

The complaints procedure was displayed in the unit. The HSE leaflet on making a complaint was available on the unit. The unit only had draft policies relating to the making, handling and investigating of complaints. Written operational policies were subsequently submitted.

Compliant: Yes

Article 32: Risk Management Procedures

The unit had no written risk management policy in place. A record of incidents and accidents was maintained and available.

Breach: There was no written risk management policy available [Article 32 (1), Article 32 (2)].

Compliant: No

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

SECLUSION

The unit had one dedicated seclusion room in the acute area. On the day of the inspection, no resident was in seclusion. The seclusion register and the clinical file of a detained patient placed in seclusion recently were reviewed. The file reviewed was in order. Evidence was recorded of the orders for seclusion, ending seclusion and of discussion with a family member. A toilet was located next door to the seclusion room. The monitor for the CCTV was located at an open desk area in the middle of the ward and was visible to staff, visitors and residents. This breach of the Rules was brought to the attention of senior clinical and managerial staff on the day of inspection. It was reported that plans were being developed to redesign the seclusion area in the near future with the building of an extension. The Mental Health Commission were informed of the non-compliance with Section 11.2. Training records on control and restraint were forwarded to the Inspectorate. A policy on seclusion was not forwarded to the Inspectorate.

Breach: The monitor for the CCTV was located at an open desk area in the middle of the ward and was visible to staff, visitors and residents [Section 11.2 and Section 9.1].

Compliant: No

ECT

No involuntary patient was receiving ECT on the day of the inspection. The policy on ECT was forwarded to the Inspectorate.

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 | Not applicable |
| 3 | Information | Not applicable |
| 4 | Absence of consent | Not applicable |
| 5 | Prescription of ECT | Not applicable |
| 6 | Patient assessment | Not applicable |
| 7 | Anaesthesia | Not applicable |
| 8 | Administration of ECT | Compliant |
| 9 | ECT Suite | Compliant |
| 10 | Materials and equipment | Compliant |
| 11 | Staffing | Compliant |
| 12 | Documentation | Compliant |
| 13 | ECT during pregnancy | Not applicable |

Compliant: Yes

MECHANICAL RESTRAINT

It was reported by the staff that mechanical restraint was not used in the approved centre. A policy stating that mechanical restraint was not forwarded to the Inspectorate.

| SECTION | DESCRIPTION | COMPLIANCE REPORT |
|---------|--|--|
| 21 | Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour | Staff reported that this was not in use on the day of the inspection. A policy stating that this was not used was not forwarded to the Inspectorate. |

Compliant: No

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

PHYSICAL RESTRAINT

It was reported by staff that physical restraint had not been used on any person currently residing on the unit. The physical restraint register was examined by the Inspectorate and was in order. The clinical file of the last person to be restrained on the unit was not obtained for examination by the Inspectorate.

Compliant: Yes

ADMISSION OF CHILDREN

No child was admitted on the day of the inspection. The unit was unsuitable as a facility for the admission of children.

Breach: The unit was unsuitable as a facility for the admission of children [Section 2.5(b)].

Compliant: No

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

There was evidence that the service was moving to compliance in notification of deaths and incident reporting. A policy was in place and a record of incidents and deaths was available.

Compliant: Yes

ECT FOR VOLUNTARY PATIENTS

The clinical file of one resident currently receiving a course of ECT was examined.

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 | Not applicable |

Compliant: Yes

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

No detained patient had been on the unit for a period in excess of three months.

Compliant: Not applicable