

## Report of the Inspector of Mental Health Services 2008

<b>HSE AREA</b>	HSE Dublin North East
<b>CATCHMENT</b>	North Dublin
<b>MENTAL HEALTH SERVICE</b>	North Dublin
<b>APPROVED CENTRE</b>	St. Ita's Hospital – Mental Health Services
<b>NUMBER OF UNITS OR WARDS</b>	8
<b>UNITS OR WARDS INSPECTED</b>	Female Admission, Male Admission, Elderly Admissions, Willowbrook, Woodview, Unit 1 Female, Unit 1 Male, Unit 9
<b>NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED</b>	139
<b>CONDITIONS ATTACHED TO REGISTRATION</b>	No
<b>TYPE OF INSPECTION</b>	Unannounced
<b>DATE OF INSPECTION</b>	21–23 July 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**

St. Ita's Hospital was a large institution with a total bed population of 139 residents that provided in-patient acute care, rehabilitation and continuing care to North Dublin (population 225,145). There were seven general adult teams, a rehabilitation team and psychiatry of later life team with admitting rights to the hospital. The Inspectorate was pleased to note that sleeping patients out from the acute wards had ceased.

Significant progress had been made in documenting practices in accordance with the rules for treatment. A system had been developed and implemented to ensure that nursing care plans were implemented and reviewed in a timely manner. Policies and procedures had been developed. All these measures had had a positive impact on direct patient care.

The unacceptable conditions within the hospital have been highlighted by the Inspectorate each year for a number of years. It is disappointing to report again that the fabric of the building remained unchanged. Piecemeal maintenance and decoration had little impact on the quality of the environment for residents. There were insufficient bathing facilities in the acute admissions wards and the furniture in Willowbrook was unacceptable. It is a source of frustration to the residents and clinical staff that no action had been taken to resolve the problems. It was subsequently reported that finance was available to install new toilet and shower facilities in the admission wards.

The debate concerning the future location of in-patient acute beds in Beaumont Hospital continued. It was reported that the project team had reconvened to look at the proposed new site. The construction of the unit will take two years from receipt of planning permission.

### Acute Care

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Female Admission	24	12	General Adult
Male Admission	24	20	General Adult
Elderly Admissions	7	7	Psychiatry of Later Life

### Rehabilitation

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Willowbrook	15	15	Rehabilitation
Woodview	16	14	Rehabilitation

### Continuing Care

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Unit 1 Female	20	20	Psychiatry of Later Life
Unit 1 Male	20	11	Psychiatry of Later Life
Unit 9	13	14	Psychiatry of Later Life

## RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. *The privacy and dignity of all residents should be of paramount importance throughout the hospital. The registered proprietor should ensure that all efforts are made to achieve privacy and dignity.*

**Outcome:** A number of residents had no bed screens in place in Willowbrook. One resident had been denied her liberty for a period of time with no recorded review, despite her status as a voluntary patient. This action was recorded in the case file and nursing notes and photographic evidence was taken by the Inspectorate. This breach of rights was reported to the senior clinical staff. The location of the CCTV monitors in the acute wards did not support privacy.

2. *Each resident should have a care plan as defined in the Regulations.*

**Outcome:** A multidisciplinary team committee has been established to oversee the development and implementation of individual care plans. The service reported that individual care plans will be fully implemented in the spring of 2009. This is reported in more detail in the section of this report on multidisciplinary care planning.

3. *All nursing care plans should be current and reviewed at set intervals.*

**Outcome:** Training by the assistant director of nursing and practice development staff has been implemented on the wards to ensure that nursing care plans are implemented and reviewed as appropriate. A number of nursing care plans review dates had lapsed in one ward. This was reported to the staff on duty.

4. *Clear policies and procedures on the use of the high observation area should be in place.*

**Outcome:** A policy was submitted. Handles had been placed on the inside of the doors.

*5. Each resident should have a physical examination completed within a six-month period.*

**Outcome:** A GP undertook the physical examinations in the rehabilitation and psychiatry of later life wards and the NCHD was responsible for the admission units. A number of physical examinations were not completed on time or not dated. This is reported in detail under Article 19 below.

*6. A clear admission policy and procedure for all residents including those admitted for respite care should be in place.*

**Outcome:** A policy was submitted that was approved in August 2008 and due for review in September 2010.

*7. All staff should adhere to best practice guidelines in relation to documentation standards. All legal forms should be signed and dated in accordance with the Rules and Codes of Practice issued by the Mental Health Commission.*

**Outcome:** There was a significant improvement in this area since the last inspection. All legal forms were appropriately completed. An audit process had been introduced to enhance compliance.

*8. All staff with responsibility for the ordering, prescribing, administration and storage of medication should ensure that they have read and understood the policy.*

**Outcome:** It was reported that this had been completed. A working group was looking at introducing a new card index system.

*9. Up-to-date signature banks should be kept and available for inspection.*

**Outcome:** There was a nursing signature bank on each unit and it was planned to have a copy of each unit's signature bank held centrally. The medical signature bank was held centrally.

*10. A maintenance plan should be agreed to address the deficits in the condition of the building. The outstanding deficits should be addressed in Woodview.*

**Outcome:** A copy of the maintenance plan for 2007 was submitted to the Inspectorate. A large number of problems had not been addressed. Woodview had been painted.

## **MDT CARE PLANS 2008**

A multidisciplinary committee had been established to oversee the development and implementation of individual care plans. The service was about to enter Phase 2 of the implementation where the latest version was due to be piloted on the admission units, Willowbrook and Unit 8, for a period of eight weeks beginning on 5 August 2008. Following this eight-week period any changes were to be made and then all staff within the service trained to use it. The service reported that individual care plans would be fully implemented in the spring of 2009. A therapeutic committee was established in September to develop and implement therapeutic programmes for residents. It was reported that this group was due to report its findings and recommendations to the senior management team soon.

## **GOOD PRACTICE DEVELOPMENTS 2008**

- Sleeping patients out from the acute wards had been discontinued.
- Clinical supervision and training in relation to the use of seclusion, physical restraint, care planning and auditing was in place for nursing staff.
- Protected engagement time and a checklist for admission procedure had been introduced on the female admissions ward.
- A multidisciplinary working group had been established to develop and implement care planning.

## **SERVICE USER INTERVIEWS**

A number of residents asked to speak with the Inspectorate on the Male Admissions Ward. They expressed satisfaction with the nursing staff, reporting that they were very helpful. They gave mixed views on the current activities programme. They were all in agreement that the condition of the building was unacceptable. In particular, they highlighted the lack of showers and toilets.

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

1. The privacy and dignity of all residents must be upheld and breaches must be rectified immediately.
2. Each resident must have an individual care plan as defined in the Regulations.
3. Each resident must have access to a range of therapeutic services and programmes based on assessed needs.
4. An audit system must be put in place to ensure that each resident has a six monthly physical examination.
5. The residents in Elderly Admissions Ward must have access to the garden.
6. There must be an appropriate range and mix of clinical staff available to residents of the hospital, based on assessed needs.
7. Funding must be provided for clerical staff to keep all records up to date.

## **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 21–23 JULY 2008**

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

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A health and safety statement on food safety was submitted. A copy of the most recent environmental health officer's report was sent to the Inspectorate team.

**Compliant:** Yes

#### **Article 7: Clothing**

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A policy on the use of night clothes during the day was submitted. No one was prescribed night clothes in the female admissions ward on the day of the inspection.

**Compliant:** Yes

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

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The service submitted a policy dated September 2007 with a review date of September 2010. Residents' personal property and possessions were recorded on admission and this record was kept separately from the individual's care plan. A staff member and the resident signed this record. Arrangements were in place for the safe keeping of money. Residents retained control of their personal property or possessions where practicable.

**Elderly Admissions:** Up-to-date lists of personal property and possessions were stored in the clinical files reviewed.

**Compliant:** Yes

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

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The service submitted a policy and procedure that met the requirements of this Article.

**Compliant:** Yes

### Article 13: Searches

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The service submitted a policy and consent form for searching. There was a policy on finding illicit substances. No recent searches had been carried out.

**Compliant:** Yes

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

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The service submitted a policy on care of the dying. An individual room on Unit 1 Female had been refurbished for use. A room had been identified on the male ward and was due for completion soon.

**Compliant:** Yes

### Article 15: Individual Care Plan

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**Elderly Admissions:** The planned integrated care plans had not yet commenced on this ward, which had been earmarked as a pilot site. The nursing care plans were up to date and showed evidence of regular evaluation.

**Adult admission wards:** There were no individual care plans in place. A number of sectors were taking part in the pilot from August 2008. The nursing care plans were in order.

**Willowbrook:** There were no individual care plans in place. A number of the nursing care plans had not been reviewed as dated. Photographic evidence was taken.

**Breach:** Residents did not have individual care plans.

**Compliant:** No

### Article 16: Therapeutic Services and Programmes

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A multidisciplinary team committee was established in September 2008 to address the deficit in the provision of therapeutic programmes. It was reported the committee was due to report to the senior management team soon.

**Elderly Admissions:** Therapeutic services and programmes were not linked to individual care plans. A clinical psychologist and occupational therapist were available to provide services to the residents on the ward.

**Acute admission wards:** There was access to a range of professionals, including a dietician. The community mental health teams were under-resourced with health and social care professionals. Team members attended weekly team reviews on the wards. There was a recreational and educational programme provided in St. Camillus' Unit and facilitated by nursing staff over five days. An art therapist and domestic science teacher provided sessional input. The programme was not linked to an individual care plan.

**Willowbrook:** The residents had access to the rehabilitation team. Since the last inspection, a senior occupational therapist had been appointed to the team. Some residents attended the recreational and educational programme with the residents from the acute wards. It was not linked to assessed needs. A number of residents remained on the ward and had no therapeutic programme.

**Breach:** There was no therapeutic programme linked to an individual care plan.

**Compliant:** No

### Article 17: Children's Education

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No child had been admitted since January 2008. There was no provision on site for children's education. Staff on the ward reported that educational needs are considered on an individual basis. No file was reviewed.

**Compliant:** Not applicable

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

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The service submitted detailed policies and procedures relating to all transfers.

**Compliant:** Yes

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

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**Elderly Admissions:** All residents had a physical examination at admission. A GP was available on a daily basis. None of the residents had being admitted for longer than six months.

**Female Admissions:** One physical examination was overdue. Staff reported that it would be conducted.

**Unit 1 Male:** All the residents were in hospital for longer than six months. A number of files were reviewed; physical examinations were not completed on a six-monthly basis. A system must be put in place to ensure all examinations are completed.

**Willowbrook:** Four physical examinations were not dated. The Inspectorate was unable to establish when the next review was due.

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

**Compliant:** No

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

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A general information booklet was available to residents on the female admission wards. It was reported that the booklet was being updated. It contained information on housekeeping issues, visiting arrangements and the service in general. Information on the resident's diagnosis was provided verbally through the team meeting and information leaflets were displayed in common areas. Information leaflets on medication, including side effects, were available to residents on request. The registered proprietor submitted written policies and procedures on the provision of information to residents.

**Breach:** Written information was not routinely provided to residents on diagnosis [Article 20 (1)(c)].

**Compliant:** No

### **Article 21: Privacy**

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**Willowbrook:** A number of bed areas had no bed screen (photographic evidence was taken). It was stated that the problems had been reported to maintenance but no action had followed.

**CCTV:** The monitor in the general adult admissions wards for use in seclusion was in view of all staff residents and visitors on the wards.

**Breach:** Article 21

**Compliant:** No

### **Article 22: Premises**

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The hospital was in a state of poor structural repair and decorative condition. Although the heating was adequate, the ventilation was poor in a number of bathrooms in the acute admission wards. A number of deficits highlighted in last year's report remained unchanged. Proposals to build additional showers remained just plans, with no time frames available. There was one shower for 24 residents on each of the admissions wards.

The service did not have a written maintenance programme in place for 2008. A copy of the 2007 minor capital maintenance programme was received. It was reported that the priority for 2008 was the provision of additional bathroom facilities in the admissions wards.

The furnishings were inadequate on Willowbrook Ward, including the lack of bed screens. Photographic evidence was taken of damaged furniture. Clinical staff reported constant reporting of problems with no outcomes. There was a level of frustration with the state of the wards. Service users voiced concern regarding the lack of bathing facilities.

There was a strategic plan dated November 2007 for the future accommodation requirements of residents currently on campus. It was reported that realisation of the plan was contingent on the receipt of financial resources. Ramps outside the female admissions ward did not meet the Regulations. The handrail was unsafe and about to fall.

**Elderly Admissions:** The shower and bathroom area had paint peeling from the ceiling and walls. Refurbishment of the staff changing and shower area had begun but was not completed. The door to the occupational area was directly off the residents washing area. There was an enclosed private garden area for residents that was well maintained but residents had no direct access to it from the ward unless accompanied by staff as the entrance was outside the locked area of the ward.

**Breach:** Article 22

**Compliant:** No

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

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The service had detailed policies in relation to this Article.

**Compliant:** Yes

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

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A health and safety statement was submitted to the Inspectorate. An updated safety statement specific to the service was due to be available before year end.

**Compliant:** Yes

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

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The monitor in two admission wards could be viewed by staff, residents and visitors. An alternative location must be found [Article 25 (1)(a)]. The service submitted a policy and procedure in compliance with this Article.

**Breach:** Article 25 (1)(a)

**Compliant:** No

#### **Article 26: Staffing**

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HSE policies applied.

**Elderly Admissions:** The agreed nursing complement for the ward was three nursing staff during the day and there were two care staff also on duty. At night, the agreed nursing staff level was one nurse and there was one care staff member also on duty. Staff reported that at times there were only two nurses on duty during the day because of staff shortages. The team had no social worker.

**General adult wards:** There was a deficit in total nursing staff numbers. A number of domestic staff had completed training to become health care assistants. They had not been appointed because their original posts would not be filled. There were plans to look at the staffing levels based on dependency levels. Access to health

and social care professionals was limited on the teams. They attended the hospital for meetings, but did not provide therapeutic services on site. They reported that they had insufficient staffing levels to do so.

**Willowbrook:** There was a nursing complement of 4 Registered Psychiatric Nurses during the day and two Registered Psychiatric Nurses at night. The residents had access to the members of the rehabilitation team by referral.

**Breach:** Article 26 (2)

**Compliant:** No

#### **Article 27: Maintenance of Records**

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A number of the medical files were bulky and it was difficult to find information in them. There were loose pages. At the time of inspection there was only 0.5 whole-time-equivalent ward clerk. There was no clerk for the administration of mental health tribunals.

A policy was submitted. It was to include the HSE policy on the creation retention and destruction of records from 1999.

Reports of inspections relating to food safety, health and safety and fire officer reports were sent to the Inspectorate team. It was reported that a full fire safety audit would be carried out and that a safety statement specific to the service would be available before year end.

**Compliant:** Yes

#### **Article 28: Register of Residents**

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The register was amended to collect the items identified in Schedule 1.

**Compliant:** Yes

#### **Article 29: Operating policies and procedures**

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There was a committee in place to write and review policies. It was to be widened to include broader multidisciplinary team involvement.

**Compliant:** Yes

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

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The service submitted a complaints policy. It was based on the HSE system. Records of complaints were reviewed during the inspection. Information was available on the wards.

**Compliant:** Yes

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

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A policy was submitted. It outlined the roles and responsibilities of staff in the approved centre. It included the procedure for reviewing incidents. Each resident had a clinical risk assessment completed on admission. There was an action plan put in place following the assessment. There was written signed procedures in place to control all risks identified in the Article.

The service reported all incidents using the national STARS Web system. The incidents were reviewed by the management team on a six-monthly basis. There was a procedure in place to respond to medical emergencies. Services used the *Trust in Care* guidelines. A record of incidents for the last six months was provided.

**Compliant:** Yes

**Article 34: Certificate of Registration**

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The certificate of registration was displayed in the approved centre.

**Compliant:** Yes

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

### SECLUSION

Seclusion was used on the admission wards and three clinical files were reviewed. All episodes of seclusion were recorded in the clinical files and a comprehensive nursing care plan was in place.

The seclusion register was reviewed and was completed appropriately. The attention to detail was excellent. Appropriate reviews were completed and documented in the register, case file and nursing care plans. Clinical reviews took place both during and after the episode of seclusion (depending on the length of time of the episode) and the resident participated in this review.

There was a seclusion room in both the male and female sides, situated in the high observation areas of the wards. The seclusion rooms were appropriate. 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	A policy was submitted. It is due for review in September 2009. An audit took place after every episode of seclusion to enhance compliance
10	Staff training	Staff had training in CPI techniques. Nurse management reported concern that there were currently no trainers in post. Of the nursing staff, 33 needed to be recertified
11	CCTV	CCTV was in place. Signage on the male side could be enhanced and consideration must be given to moving the monitors to enhance the residents privacy and dignity
12	Child patients	Not applicable

**Breach:** Section 11

**Compliant:** No

**ECT**

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ECT was no longer provided on site.

**Compliant:** Not applicable

**MECHANICAL RESTRAINT**

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There were no entries in the mechanical restraint register. No file was reviewed. Clinical staff reported that mechanical restraint was not routine practice. There was a policy in place.

SECTION	DESCRIPTION	COMPLIANCE REPORT
21	<b>Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour</b>	Files were reviewed in Unit 1 Male. A number of residents had been prescribed chairs, bed rails and lap belts. The prescription was recorded weekly in the file by the registered medical practitioner and signed by the treating consultant psychiatrist. In a small number of cases it was noted that the duration of usage was not clear. Clinical staff were informed on the day and this was rectified.

**Compliant:** Yes

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

### PHYSICAL RESTRAINT

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The clinical practice forms for physical restraint were all completed. The service has made considerable improvements in the recording of physical restraint. All episodes were appropriately recorded on the clinical practice forms and a written account was in the case file.

Below is a summary of the Inspectorate's findings in relation to compliance with 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	Compliant
6	Clinical governance	A policy was submitted. There was an annual report available.
7	Staff training	Clinical staff reported that staff were trained in CPI techniques. Nurse management reported concern that there were currently no trainers in post. 33 nursing staff needed to be re-certified.
8	Child residents	Not applicable

**Breach:** Section 7

**Compliant:** No

### ADMISSION OF CHILDREN

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No child had been admitted to the service since January 2008. The service was unable to meet the requirements of Section 2.5. There were no policies in place.

An action plan to address the deficits was submitted to the Mental Health Commission in July 2008.

**Breach:** Section 2.5

**Compliant:** No

## **NOTIFICATION OF DEATHS AND INCIDENT REPORTING**

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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.

<b>SECTION</b>	<b>DESCRIPTION</b>	<b>COMPLIANCE REPORT</b>
<b>2</b>	<b>Notification of deaths</b>	Compliant
<b>3</b>	<b>Incident reporting</b>	Compliant
<b>4</b>	<b>Clinical governance</b>	The policy should be updated to include procedure for reviewing incidents and sent to the Inspectorate.

**Breach:** Section 4

**Compliant:** No

## **ECT FOR VOLUNTARY PATIENTS**

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ECT was no longer provided on site.

**Compliant:** Not applicable

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

There was no patient on the female admission ward who met the criteria for Section 60. No file was reviewed. There were no detained children admitted to the approved centre since January 2008. Section 61 did not apply.

**Compliant:** Not applicable