

Report of the Inspector of Mental Health Services 2008

HSE AREA	HSE Dublin Mid Leinster
CATCHMENT	Kildare/West Wicklow
MENTAL HEALTH SERVICE	Kildare/West Wicklow
APPROVED CENTRE	Lakeview Unit, Naas General Hospital
NUMBER OF UNITS OR WARDS	1
UNITS OR WARDS INSPECTED	Lakeview Unit
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	29
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	13 October 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 facilitated a feed back meeting following the inspection with members of nurse management, the clinical director and the managers of psychology, occupational therapy and social work.

DESCRIPTION

Lakeview Unit was situated in Naas General Hospital. The bedrooms and some of the day areas were located on the ground floor of the unit while the dining area, therapy area and offices were on the first floor. The unit was locked on the day of inspection. Although the unit had 29 beds, the service had an additional 10 residents who were admitted but who could not be accommodated in the approved centre. Two were detained patients on pass, three were residents who had been transferred to St. Brendan's Hospital, one had been transferred to St. John of God Hospital, and four had been admitted to hostels within the service, which had resulted in respite beds being closed.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Lakeview	29	31	5 general adult teams 1 rehabilitation team

The service reported that five service users were waiting for admission but there were no vacancies. The approved centre had been operating over capacity for some time and on at least three recent occasions the seclusion room was used as a bedroom.

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. *A system of multidisciplinary care planning should be introduced as soon as possible.*

Outcome: No progress was reported on this issue and none of the residents had a multidisciplinary team care plan.

2. *Staff in the therapy area should write protocols for each group.*

Outcome: The occupational therapist and nurses in the therapy area had completed a significant amount of work on developing protocols for the groups.

3. *Staff in the therapy area should record interventions and outcomes in clinical notes.*

Outcome: These interventions were being recorded in the nursing section of the integrated clinical notes.

4. *Staffing levels should be increased and skill mix broadened on the rehabilitation team so the multidisciplinary team will contain all core disciplines.*

Outcome: Funding had not been made available to provide a core rehabilitation team.

5. *Staffing levels and skill mix on all of the sector teams should reflect the team composition laid down in Vision for Change.*

Outcome: There had been no progress on this recommendation due to lack of funding and workforce ceilings.

6. *The management team of the service should be expanded to include all heads of discipline and should ensure appropriate service user input.*

Outcome: The tripartite management structure remained in operation and the Local Health Manager met with this group regularly. In addition, a heads of discipline meeting had been established. The heads of discipline informed the Inspectorate that the remit and status of this meeting in relation to service management had not been clarified and there was no forum in place to meet with their Local Health Manager. Following the inspection, the service reported that the management team for Kildare/West Wicklow would include from October 2008 all health and social care professionals as well as the clinical director, director of nursing, hospital manager, and heads of clinical psychology, social work and occupational therapy. It was reported that this team would meet every month with the Local Health Manager and the general manager as part of the management team structure.

MDT CARE PLANS 2008

It was reported to the Inspectorate that the home care team was using multidisciplinary team care plans, however, none of the residents present at the approved centre were admitted by this team. None of the residents admitted on the day of inspection had a multidisciplinary team care plan. All of the teams, with one exception, met on the unit every week. Some of the teams documented the MDT meetings in the clinical files and some of the teams also recorded which team members attended the meeting. The service was unable to say when individual care plans might be implemented in the approved centre and there was no specific time frame or plan for how this would be progressed. Following the inspection, the service reported that a sub-group had been established to implement MDT care planning in 2009.

GOOD PRACTICE DEVELOPMENTS 2008

- The Refocusing project was continuing on the unit and the next step being planned was for the introduction of dedicated nursing time for residents.
- Heads of discipline were now involved in signing policies and procedures.

SERVICE USER INTERVIEWS

None of the residents asked to speak to the Inspectorate.

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

1. Funding should be made available to develop alternatives to in-patient admissions.
2. Each resident must have an individual multidisciplinary team care plan.
3. All of the policies required under the Regulations, Rules and Codes of Practice must be developed, implemented, signed and up to date. There must be a system in place for regular review of the policies in line with the Regulations or Recommendations of the Inspectorate.
4. As the unit admits children, all staff must have Garda vetting. While this happens automatically for new staff or promoted staff, a system should be in place to ensure that existing staff, especially those in the service for a number of years, are also subject to Garda vetting.
5. Funding should be made available to fully resource the teams, in particular the rehabilitation team.

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 13 OCTOBER 2008

Article 4: Identification of Residents

The approved centre indicated in its implementation plan to the MHC that identity bracelets would be introduced within the first six months of 2008. This had not been implemented at the time of inspection and was reported to be tied up in with the hospital's accreditation process and that funding was not available.

Breach: The agreed system for identification of residents was not in place.

Compliant: No

Article 6 (1-2) Food Safety

Food was prepared in the main hospital kitchens which were subject to hygiene audits. Up-to-date Hazard Analysis Critical Control Points (HACCP) reports were available. An Environmental Health Officer's report was available dated 2006. There were a number of issues outstanding in the report.

Breach: There were a number of issues outstanding in the Environmental Health Officer's report.

Compliant: No

Article 7: Clothing

A policy was implemented in 2004 but did not have a review date and was not signed. Although a policy was not required for compliance with this Article, all policies and procedures of an approved centre must be reviewed at least every 3 years, or on the recommendation of the Inspector of Mental Health Services [Article 29]. Following inspection, the service reported that the policy review date had been set for 1 March 2009. The service was compliant with Article 7 (1) and Article 7 (2).

Compliant: Yes

Article 8: Residents' Personal Property and Possessions

A policy was implemented in November 2006, but had no review date and was not signed. Following inspection, the service reported that the policy was due for review in March 2009. A record of property was maintained and residents had access to wardrobes and lockers for keeping their own personal property and possessions.

Compliant: Yes

Article 11 (1-6): Visits

A policy on visits had been implemented since last year. The service was compliant with other aspects of this Article.

Compliant: Yes

Article 12 (1-4): Communication

The approved centre indicated in its implementation plan to the MHC that a policy on communication would be implemented within the first six months of 2008. On the day of inspection no policy was in place. Following inspection, the service reported that a policy would be signed off in December 2008.

Breach: Article 12 (3)

Compliant: No

Article 13: Searches

The approved centre indicated in its implementation plan to the MHC that a policy on searches would be implemented within the first six months of 2008. On the day of inspection no policy was in place. Following inspection the service reported a plan to implement a policy before March 2009.

A policy on the finding of illicit substances was implemented on 1 March 2004, but did not have a review date, nor was it signed. Following inspection, the service reported the policy would be reviewed in March 2009.

Breach: Article 13 (1)

Compliant: No

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

A policy had been implemented in 2008. The approved centre was compliant with other aspects of this Article.

Compliant: Yes

Article 15: Individual Care Plan

None of the residents had an individual care plan. There was no agreement about implementing individual multidisciplinary care plans on the unit despite the service indicating in its implementation plan that these would be introduced in 2007. Following the inspection, the service reported that a sub-committee had been established to introduce care planning in 2009.

Breach: None of the residents had an individual care plan.

Compliant: No

Article 16: Therapeutic Services and Programmes

A range of therapeutic programmes was provided to every resident but this was not based on an individual multidisciplinary team care plan [Article 16 (1)]. The therapeutic programme for the week was decided by residents and staff from the therapy area at a weekly community meeting and was regularly reviewed. A written programme was then posted around the unit. The occupational therapist and activity nursing staff had developed protocols for the groups and had introduced more elements of choice and independence for residents.

Breach: Article 16 (1)

Compliant: No

Article 17: Children's Education

No policy had been formulated regarding the issue of children's education. There was no documentation in the clinical file reviewed indicating that educational requirements had been assessed.

Breach: No assessment of educational need recorded in clinical file.

Compliant: No

Article 18: Transfer of Residents

A policy and procedures document had been introduced in 2008.

Compliant: Yes

Article 19 (1-2): General Health

It was reported that residents had speedy access to general health services in the hospital by referral from the NCHD. Residents had their general health needs assessed in the Emergency department or on admission to the unit. Two clinical files of residents who had been admitted longer than six months were reviewed. One file documented that the resident had not consented to a general medical review and the other documented a physical review.

Compliant: Yes

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

No written operational policies and procedures were in place for the provision of information to residents. Following the inspection, the service reported that a policy would be in place by March 2009.

Breach: Article 20 (2)

Compliant: No

Article 21: Privacy

The dormitory areas had blinds on the external windows and on the doors to the corridors. Each bed had a curtain around it. Each resident had a locker and wardrobe, except on those occasions when the seclusion room was being used as a bedroom. The unit had been unable to facilitate the numbers of service users that presented for admission and some had had to be transferred to other approved centres, compromising their privacy and dignity. This was not an acceptable situation for service users and their families or carers who present in emergency or acute situations.

Breach: The privacy and dignity of residents was not provided for in all cases.

Compliant: No

Article 22: Premises

The unit was well maintained and was clean on the day of inspection. However, there was limited space available for residents and staff. There were no private suitable spaces available to accommodate clinical psychologists, social workers or occupational therapists from the community to work with residents on the unit. On occasion residents had to sleep in the seclusion room as there were not enough bedrooms.

Breach: The premises were not maintained and developed with due regard to the needs of residents and staff [Article 22 (3)].

Compliant: No

Article 26: Staffing

Each of the social workers had dedicated time on the unit, which meant that there was a social work presence on the unit every day to deal with any relevant issues. Psychology presence on the unit was very limited and not all teams had a psychologist. Input from health and social care professionals was further hampered by the unit's lack of available space that could be used for individual or group interventions. The rehabilitation team had no psychologist or occupational therapist, which severely limited its work.

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

STAFF MEMBER	DAY	NIGHT
CNM2	1	–
CNM1	0	1
Staff nurse	5	3
Senior Occupational Therapist	1	N/A
CNM3	1	1
CNM2 ECT/CLOZARIL	1	N/A

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

Compliant: No

Article 28: Register of Residents

This was not inspected on the day and the approved centre was non-compliant in the previous year's inspection. The approved centre did not submit a copy of the register as they indicated they would in correspondence with the Inspectorate following the inspection. The Inspectorate had no evidence that the register had been amended following the previous year's inspection.

Breach: There was no evidence that the information required by the Regulations was included on the register of residents.

Compliant: No

Article 29: Operating policies and procedures

A multidisciplinary policy committee had been reviewing the policies, protocols and procedures for the unit. As was the case in the previous year's inspection, many of the policies required by the Regulations had not yet been formulated, others were in draft form, and some were in need of review. This had been highlighted in the previous year's report and the required work had not been completed.

Breach: Policies had not been reviewed on the recommendation of the Inspectorate in the previous year's report. Some of the policies had no date for review included and some had dates for review which had already past.

Compliant: No

Article 32: Risk Management Procedures

The unit did not have a comprehensive risk management policy in place [Article 32 (1)]. It was reported that a working group had been established to examine the issue of clinical risk management and assessment. The service reported that a risk policy had been implemented since the inspection. A system of recording, reporting and learning from serious incidents was in place.

Breach: Article 32 (1)

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	Non-compliant. There was no record of patient being informed of the reason for, and likely duration of, seclusion [Section 2.9] and no record of whether next of kin had been informed [Section 2.10].
3	Patient dignity and safety	Compliant
4	Monitoring of the patient	Compliant
5	Renewal of seclusion orders	Compliant
6	Ending seclusion	Compliant
7	Facilities	Non-compliant. As a result of overcrowding on the unit, the seclusion room was being used as a bedroom on occasions [Section 7.5].
8	Recording	Compliant
9	Clinical governance	Non-compliant. There was no record of discussion at MDT [Section 9.2]. The seclusion policy had not been reviewed since 2002, even though it is required to be reviewed annually [Section 9.1(d)].
10	Staff training	Compliant
11	CCTV	Compliant
12	Child patients	Not applicable

Breach: Section 2.9, Section 2.10, Section 7.5, Section 9.2, and Section 9.1(d).

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	Not applicable

Compliant: Yes

MECHANICAL RESTRAINT

The Inspectorate was informed that mechanical restraint was not used on the unit. The Inspectorate requested a written statement or policy confirming this but this was not submitted by the service.

SECTION	DESCRIPTION	COMPLIANCE REPORT
21	Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour	The Inspectorate was informed that mechanical restraint was not used on the unit.

Breach: Section 18 .1 (a)

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	Non-compliant. There was no record that patients were informed about the reasons for physical restraint [Section 2.9] and no record of whether next of kin had been informed [Section 2.10].
3	Resident dignity and safety	Compliant
4	Ending physical restraint	Compliant
5	Recording use of physical restraint	There was no record that patients were informed about the reasons for physical restraint and no record of whether next of kin had been informed.
6	Clinical governance	Non-compliant. There was no record of discussion with MDT [Section 6.2].
7	Staff training	Compliant
8	Child residents	Not applicable

Breach: Section 2.9, Section 2.10, and Section 6.2.

Compliant: No

ADMISSION OF CHILDREN

Five children had been admitted from January to October 2008.

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	Non-compliant. There was no policy on admission of children [Section 2.5(a)]. Age-appropriate facilities were not provided (2.5(b)). Staff informed the Inspectorate that new staff had Garda vetting but that staff who had been in the service for some time had not been subject to Garda vetting [Section 2.5(d)(i)]. Following the inspection, the service reported that the management team was not aware of any staff who had not had Garda vetting. Age-appropriate advocacy was not available [Section 2.5(g)].
3	Treatment	Compliant
4	Leave provisions	Compliant

Breach: Section 2.5(a), Section 2.5(b), Section 2.5(d)(i), and Section 2.5(g).

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	Compliant
4	Clinical governance	Non-compliant. A comprehensive risk management policy was not in place. Although the approved centre had a system for reviewing and learning from incidents, there was no policy that reflected the practices and systems in place, including indicating roles and responsibilities in relation to risk management. Following inspection, the service reported that a risk policy had since been implemented.

Breach: There was no policy.

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	Not applicable

Compliant: Yes

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

The service reported that one detained patient had been admitted for longer than three months and this clinical file was reviewed. The Section 60 requirements were satisfied.

Compliant: Yes