

# Report of the Inspector of Mental Health Services 2008

<b>HSE AREA</b>	HSE Dublin Mid Leinster
<b>CATCHMENT</b>	East Wicklow
<b>MENTAL HEALTH SERVICE</b>	East Wicklow
<b>APPROVED CENTRE</b>	Newcastle Hospital
<b>NUMBER OF UNITS OR WARDS</b>	2
<b>UNITS OR WARDS INSPECTED</b>	Glencree Avonmore
<b>NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED</b>	60
<b>CONDITIONS ATTACHED TO REGISTRATION</b>	No
<b>TYPE OF INSPECTION</b>	Announced
<b>DATE OF INSPECTION</b>	23 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

Newcastle Hospital was located in Co Wicklow. It had 60 beds and on the day of inspection there were 44 residents. The approved centre had one admissions unit, Glencree, and a long stay continuing care unit, Avonmore, which catered mainly for residents with dementia. Four general adult teams could admit to the two units. At the time of inspection Glencree was reconfiguring some rooms to make an accessible bathroom area. Once this was complete refurbishment of the kitchen area was due to commence. One of the rooms on Avonmore had been converted into a conservatory.

<b>WARD</b>	<b>NUMBER OF BEDS</b>	<b>NUMBER OF RESIDENTS</b>	<b>TEAM RESPONSIBLE</b>
Glencree	30	18	4 general adult teams
Avonmore	30	26	4 general adult teams

The Inspectorate was impressed on the day with the quality of the cleanliness of the unit as a whole. In general, furnishings and decor were of a high standard, with a few minor exceptions in floor covering. Staff spoke highly of the work of the Friends of Newcastle Hospital whose voluntary work contributed greatly to the provision of funds for extra facilities for the residents.

## RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. *An occupational therapy manager should be appointed to the wider catchment of 300,000, with a brief similar to that of the principal social worker, in order to attract staff and develop services in line with the national policy document.*

**Outcome:** No funding had been made available for the provision of an occupational therapy manager to the service.

2. *Specialist teams should be appointed and adequately staffed with all disciplines.*

**Outcome:** One consultant psychiatrist had taken on the role of specialist with an interest in psychiatry of later life, intellectual disability, and rehabilitation. However, there had been no provision of additional team members to support this function.

3. *The multidisciplinary team weekly care plan template should be further developed into an individual care plan as defined in the Regulations to include consultation with the resident, goal setting, time frames and regular review.*

**Outcome:** MDT care plans were introduced within Glencree in November 2007. It was hoped to introduce similar care plans to Avonmore in the near future.

4. *The senior management team should roll out its seven-year plan, which is directly aligned to the national policy document A Vision for Change.*

**Outcome:** The seven-year plan has come to an end, so a new plan will have to be drawn up in conjunction with all stake- holders.

5. *The therapeutic activities programme should be linked to a needs-based assessment and documented in the care plan template.*

**Outcome:** Owing to the absence of a full therapeutic input by an appropriate mix of disciplines, individual therapeutic programmes cannot be fully comprehensive. Therapeutic services and programmes could not be linked to care plans as not all residents had individual MDT care plans.

## MDT CARE PLANS 2008

The residents on Avonmore did not have individual multidisciplinary team care plans. On Glencree, the admission unit, there was evidence in the clinical files reviewed that the MDT weekly care plan meeting was taking place. The unit used a template that was inserted at the relevant place in the contemporaneous clinical notes for completion at the team meeting. The template allowed recording of the disciplines involved and the planned actions and goals. However, in most cases the resident's progress rather than goals or planned interventions was being recorded. The template had not been signed by the resident in the files reviewed although there was a place in the template for this. The residents did not attend team meetings but the service reported that their views were sought at the medical and nursing ward rounds prior to the team meetings. It was the view of the Inspectorate that if these templates were being completed correctly they would meet the minimum requirements of the Regulations.

## GOOD PRACTICE DEVELOPMENTS 2008

- In Glencree, there was a plentiful supply of literature on diagnoses and illnesses available to residents in the sitting-room. The supply of general books and games had recently been renewed.
- A number of nursing staff were pursuing a degree in Nursing with the support and sponsorship of management.
- It was noted that nursing staff took a very proactive role in talking with patients after periods of seclusion. The Inspectorate would encourage other members of the multidisciplinary team to use this event to engage with patients in a similar manner, as outlined in the Rules for the Use of Seclusion, Section 6.3.

- In Avonmore, there was access to a speech and language therapist who had carried out assessments on swallowing function with a number of residents, and it was planned to do assessments on all residents over the forthcoming months.
- A physiotherapist was working in a designated area in Avonmore five days a fortnight, offering a full physiotherapy service to residents.
- Staff on Avonmore had a training day with the psychologist, speech and language therapist and dietician.

### **SERVICE USER INTERVIEWS**

Two residents asked to speak to the Inspectorate. They had specific concerns regarding the provision of information to them about their care and treatment. These issues were discussed with nursing staff on the unit and the Inspectorate was assured that one of the issues had been addressed by the end of the inspection. The two residents were generally satisfied with their care and treatment, however, one complained that a diabetic diet was not provided. While nursing staff were of the opinion that the complaint was in relation to provision of appropriate sweetener, the complaint of the resident was in relation to his diabetic diet in general. Following the inspection, the service reported that diabetic diets were always available and provided for on Glencree.

### **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 multidisciplinary team care plan.
2. Therapeutic services and programmes must be linked to individual care plans.
3. Funding should be made available to fully staff the teams with core members of the disciplines.
4. Funding should be made available to address the privacy issues in Room 9 in Avonmore. The service reported that this area had been decommissioned as renovations had commenced.
5. Outstanding recommendations from last year's report should be progressed.
6. An occupational therapy manager should be appointed to the wider catchment of 300,000, with a brief similar to that of the principal social worker, in order to attract staff and develop services in line with the national policy document.
7. Specialist teams should be appointed and adequately staffed with all disciplines.
8. A local service plan should be developed once the HSE Dublin Mid Leinster plan has been agreed.

## **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 23 SEPTEMBER 2008**

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

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Food safety reports were made available to the Inspectorate and highlighted a number of concerns. The service reported that these concerns were being addressed.

**Compliant:** Yes

#### **Article 15: Individual Care Plan**

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The residents on Avonmore did not have individual multidisciplinary team care plans. Glencree, the admission unit, used a template that was inserted at the relevant place in contemporaneous clinical notes for completion at the team meeting. The template allowed recording of the disciplines involved and the planned actions and goals. In most cases this had been completed to indicate the resident's progress but did not indicate goals or planned interventions. This template had not been signed by the resident in the files reviewed.

**Breach:** Not all residents had a care plan. The care plans in use were not being completed to record goals and planned interventions.

**Compliant:** No

#### **Article 16: Therapeutic Services and Programmes**

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In Glencree, there was very limited access to therapeutic services and programmes appropriate to the needs of the residents mainly due to the dearth of health and social care professional in the service. Avonmore had access to a wide range of physical therapies based on the needs of the residents, including physiotherapy, speech and language therapy, chiropody and dietetics.

**Breach:** Therapeutic services available on Avonmore were not linked to MDT care plans [Article 16 (1)]. Residents on Glencree did not have access to an appropriate range of therapeutic services and programmes mainly due to the absence of occupational therapy and the limited number of other core health and social care professionals in the service [Article 16 (1)].

**Compliant:** No

### **Article 17: Children's Education**

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Children's education was facilitated where necessary through liaison with parents and schools.

**Compliant:** Yes

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

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A policy was in place for the transfer of residents and the transfer of care to another approved centre or hospital.

**Compliant:** Yes

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

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The units had a system for ensuring that six-monthly general health reviews were taking place. There was evidence in the files reviewed that these reviews had been completed. Physical examinations were conducted every six months or more frequently if necessary. There was good access to other medical disciplines as required.

**Compliant:** Yes

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

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An information booklet on the hospital was provided to residents. Other booklets on illnesses and medication were also provided. Doctors signed in the notes of residents that they had been informed about effects of medication. Each resident was assigned a key nurse on a daily basis and information on this was posted on the notice-board. A visitors room was available to residents on each ward. A noticeboard advised residents about the advocate and times of attendance.

**Compliant:** Yes

### **Article 21: Privacy**

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Glencree had one single room. Avonmore had three single rooms. In addition, each ward had one 3-bed dormitory. The remainder of the accommodation was in 6-bed dormitories, where each bed had curtains for privacy. The privacy of residents in Room 9 in Avonmore was compromised as it was a thoroughfare to a day room and conservatory. Staff reported that there were plans to erect a partition to enhance privacy. Following the inspection, the service reported that this area had been decommissioned while renovation works were in progress.

**Breach:** Residents' privacy was compromised in Room 9, Avonmore.

**Compliant:** No

### **Article 22: Premises**

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In Glencree, the floor on corridor from the unit into the kitchen and dining room was damaged and created a trip hazard. The male toilets were in need of upgrading, and pipework that was perishing was exposed. The bathroom that contained a shower had paint peeling from the walls and was in need of redecoration. In Avonmore, the floor on the main corridor was damaged, creating trip hazard, and was in need of repair.

The Inspectorate was informed later that renovations had been carried out since the inspection.

**Breach:** Specific areas in the approved centre were in need of repair [Article 22 (4)].

**Compliant:** No

**Article 26: Staffing**

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There were five nursing staff daily in Glencree, including one CNM 2. In addition, two domestic staff were on duty. On the day of inspection, one student nurse was assigned to the ward. Two nursing staff operated at night. There was regular training in aspects of the Mental Health Act 2001 and training in physical restraint was on an continuing basis and was provided in-house. A record of training was provided to the Inspectorate. There was no occupational therapy input to the service and psychology and social work input was limited.

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

**Compliant:** No

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

### SECLUSION

Glencree had a seclusion area consisting of an ante-room and a seclusion room. CCTV in the room was directed at the blind spot behind the door. The monitor was in the ante-room. Both areas had murals and a door sign described it as a quiet room. The seclusion register was reviewed and was in order. The clinical documentation by nursing staff in relation to seclusion episodes was of a high standard and clearly recorded what happened during and after seclusion, including the opportunities provided to patients to discuss what had happened.

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	<b>Orders</b>	Non-compliant. No record of whether or not next of kin had been informed of seclusion was recorded in the clinical files reviewed. Following inspection, the service reported that records had been available at the time of inspection, but these were not made available either during or after the inspection.
3	<b>Patient dignity and safety</b>	Compliant
4	<b>Monitoring of the patient</b>	Compliant
5	<b>Renewal of seclusion orders</b>	Compliant
6	<b>Ending seclusion</b>	Compliant
7	<b>Facilities</b>	Compliant
8	<b>Recording</b>	Compliant
9	<b>Clinical governance</b>	Non-compliant. There was no record in the clinical files reviewed that episodes of seclusion were discussed at the MDT meetings [Section 9 (2)]. Following inspection, the service reported that episodes of seclusion were discussed at MDT meetings but no evidence of this was made available to the Inspectorate. The service had an up-to-date seclusion policy and the Inspectorate drew attention to the requirement for this to be reviewed annually.
10	<b>Staff training</b>	Compliant
11	<b>CCTV</b>	Compliant
12	<b>Child patients</b>	Compliant

**Breach:** No record in the clinical files reviewed of whether or not next of kin had been informed [Section 2.10]. No record in the clinical files reviewed of seclusion episodes being discussed with MDT [Section 9.2].

**Compliant:** No

## ECT

The ECT register was reviewed and was in order. None of the patients on the unit was receiving ECT at the time of inspection. No detained patients had received 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	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	Not applicable
9	ECT Suite	Compliant
10	Materials and equipment	Compliant
11	Staffing	Compliant
12	Documentation	Not applicable
13	ECT during pregnancy	Not applicable

**Compliant:** Yes

## MECHANICAL RESTRAINT

It was reported to the Inspectorate that mechanical restraint was not used in this service. The service was asked to submit a written statement or policy to this effect to the Inspectorate but did not do so.

SECTION	DESCRIPTION	COMPLIANCE REPORT
21	<b>Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour</b>	The service had a detailed policy on mechanical restraint for enduring self-harming behaviour that met the requirements of Part 5 of the Rules. There was also documented advice on the use of cot sides dated January 2007 and advice on the use of Posey criss-cross vests in the care of elderly residents on Avonmore.

**Breach:** The service did not submit the written statement on policy requested by the Inspectorate.

**Compliant:** No

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

### PHYSICAL RESTRAINT

Physical restraint was not used in Avonmore. In Glencree, nursing staff were instructed in crisis prevention intervention (CPI). Three staff members were qualified instructors, and training was continued on a rolling basis. A record of training was made available to the Inspectorate.

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 in the clinical files reviewed that the resident was informed about the reason for, or likely duration of, physical restraint [Section 2.9]. There was no record in the clinical files reviewed of whether or not 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	Compliant
6	Clinical governance	Non-compliant. There was no record in the clinical files reviewed that the incident had been reviewed by the multidisciplinary team [Section 6.2].
7	Staff training	Compliant
8	Child residents	Compliant

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

**Compliant:** No

## ADMISSION OF CHILDREN

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Six children aged 16 or 17 were admitted in the year to date. There were no children admitted on the day of the inspection. While it was the policy of the unit not to admit children, when they required admission they were accommodated in a segregated bedroom and bathroom and had a designated nurse.

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. Age appropriate facilities were not available [Section 2.5(b)]. Age-appropriate advocacy was not available [Section 2.5(g)].
3	Treatment	Compliant
4	Leave provisions	Compliant

**Breach:** Section 2.5(b) and Section 2.5(g).

**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.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	Notification of deaths	Compliant
3	Incident reporting	Compliant
4	Clinical governance	Compliant

**Compliant:** Yes

## 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 no patient had been detained longer than three months.

**Compliant:** Not applicable