

Report of the Inspector of Mental Health Services 2008

HSE AREA	HSE Dublin North East
CATCHMENT	Louth/Meath
MENTAL HEALTH SERVICE	Louth/Meath
APPROVED CENTRE	St. Brigid's Hospital, Ardee
NUMBER OF UNITS OR WARDS	3
UNITS OR WARDS INSPECTED	Unit 1 St. Ita's Our Lady's
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	54
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	1 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. Brigid's Hospital provided in-patient care for acute admissions and elderly continuing care for the Louth area. At the time of inspection, there were two continuing care wards but these were due to merge within a few weeks into a single ward with 20 residents and this was due to be under the clinical responsibility of the psychiatry of later life team for Louth from September. The total number of residents who could be accommodated in the approved centre was 54.

Acute care was provided in the main hospital building and plans were being made to extend into the soon-to-be-vacated ward next door. There is also an acute care facility in Navan. There was no rehabilitation team but there was a team for psychiatry of later life. The future of the hospital was uncertain and reflected the uncertainty in the provision of a regional hospital in the area, which would provide the location for acute care for Louth and Meath.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Unit 1	30	17	General Adult
St. Ita's Unit	10	10	General Adult
Our Lady's	14	14	General Adult

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. *The approved centre should introduce individual care plans as defined in the Regulations.*

Outcome: There had been no progress on the introduction of care plans. Satisfactory care plans were available elsewhere in the service but had not been introduced in St. Brigid's Hospital.

2. *The approved centre should provide therapeutic activities based on individual needs assessment and linked to the individual care plan.*

Outcome: Although there were no therapeutic activities linked to individual care plans, two occupational therapists had been appointed to the service and were in the process of developing therapeutic programmes.

3. *All of the outstanding recommendations from the 2006 report should be progressed in full.*

Outcome: There had been some progress in meeting these recommendations. The issue of care planning remained a serious deficit.

4. *The outstanding maintenance work in St. Ita's Unit and Our Lady's Unit should be completed as soon as possible.*

Outcome: The bathroom and toilets in Our Lady's ward had been upgraded. The wards were due to transfer to a newly renovated area from September.

5. *The approved centre should ensure that policies are written for residents and not only for patients.*

Outcome: This had been achieved.

MDT CARE PLANS 2008

Clinical files were now integrated. However there had been no progress in implementing care plans within St. Brigid's Hospital. Care plans introduced elsewhere in the service (Department of Psychiatry, Navan) were suitable for introduction to St. Brigid's Hospital. The barriers to introduction of basic care plan appeared to be resistance to changing current practices. All clinical teams had weekly team meetings on the acute unit, apart from one sector team which held its clinical meetings in the sector headquarters 20 kilometres away. This meant that the nursing staff from the unit, including the primary nurses could not attend. It was difficult to see how effective care planning could take place with this practice. There were no regular team meetings in the continuing care wards. However as the residents in these wards come under the care of one psychiatrist in later life it is likely that this will change.

GOOD PRACTICE DEVELOPMENTS 2008

- There was one session of occupational therapy weekly on each rehabilitation ward and a therapeutic activity programme 3.5 days a week on Unit 1.
- The resident information booklets and notice boards were excellent.
- There was a single integrated file for each resident.
- A moving and handling assessment was completed on each resident in Our Lady's Ward.
- A choice in food was introduced.
- Photo identification was placed on the medication sheets.
- A new premise was nearing completion. A number of residents had been suitably placed in more appropriate accommodation based on need.

- The enthusiasm of nursing staff was evident throughout the hospital. A number of audits had been carried out, informative posters about seclusion and restraint had been developed and regular training presentations in policies were held by the nursing staff.
- The patient information system was excellent and was provided in Polish and Russian.
- A nurse manager had been appointed to the admission unit which meant that there was continuity across shifts and improvements in ward management.

SERVICE USER INTERVIEWS

Two service users spoke with the Inspectorate. Both complained of feeling bored at times. Apart from this both were satisfied with their care and their environment.

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 care plan as defined in the Regulations. If necessary specific training should take place.
2. There must be a standard for providing a full psychiatric review for each resident in continuing care.
3. There must be funding provided to adequately resource the sector teams and speciality team with health and social care professionals.

PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE, AND SECTION 60, MHA 2001

INTRODUCTION

In 2008, the inspection focused on areas of non-compliance identified in 2007. In addition, the Inspectorate re-inspected compliance with all the articles in part three of the Regulations (15–21 and 26) and the Rules and the Codes of Practice in each approved centre. In 2008, two new codes of practice were issued and compliance with them was inspected. Where conditions were attached, they were inspected in detail. Evidence of compliance was established through three strands:

- Inspection of compliance where there was a breach in 2007. This was cross-referenced with the action plan submitted to the MHC Standards and Quality Assurance Division.
- Written evidence requested prior to the inspection, for example policies.
- Evidence gathered during the course of the inspection from staff, service users, photographic evidence and photocopies.

2.1 EVIDENCE OF COMPLIANCE WITH CONDITIONS ATTACHED TO REGISTRATION

As no conditions were attached, this was not applicable.

2.2 EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d) ON 1 JULY 2008

Article 8: Residents' Personal Property and Possessions

A policy was submitted. It was reported that all units maintain a register of personal property.

Compliant: Yes

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

The service was compliant with the Article. In addition, the service had become involved in developing a hospice-friendly hospital policy. This was to be introduced on the new continuing care ward in September.

Compliant: Yes

Article 15: Individual Care Plan

Residents did not have an individual care plan as defined in the Regulations. Integrated notes had been introduced on all wards. No time frame was indicated for introducing care plans.

Compliant: No

Article 16: Therapeutic Services and Programmes

All areas access to therapeutic programmes was limited and they were not linked to an individual care plans (see Article 15 above). Each ward had access to one session a week of occupational therapy. It was insufficient to meet the needs of the residents. The assessments were documented in the integrated notes. In addition the residents had access to complementary therapy.

Breach: Article 16 (1)

Compliant: No

Article 17: Children's Education

There was no provision for the education of children. Staff reported that children were not admitted to this unit and those requiring admission were directed to Navan.

Article 18: Transfer of Residents

The service was compliant with this Article.

Compliant: Yes

Article 19 (1-2): General Health

There was access to junior medical staff on request and appropriate procedures were in place for accessing a general hospital. In the files reviewed there was evidence that all general health examinations had been completed in the last six months.

Female residents were offered current national screening programme Breast Check if appropriate. It was reported a number had refused the service.

There was a policy on medical emergencies.

Compliant: Yes

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

Continuing Care: A new information booklet was given to each resident. Given the profile of the residents, information on medication and diagnosis was given verbally.

Admission Unit: An excellent information booklet was available that met the requirements of this Article. It was also available in Polish and Russian. The service also provided extensive accessible information on diagnosis and medication. The unit notice-boards had an extensive number of relevant information notices.

Compliant: Yes

Article 21: Privacy

The service was compliant.

Compliant: Yes

Article 22: Premises

Continuing Care: The deficits identified last year had been addressed. A new premises was nearing completion on the day of inspection. It was due to provide 20 beds. It was reported that the unit was to be operational by September and would be the clinical responsibility of the psychiatry of later life team.

Admission Unit: The environment in the admission unit was satisfactory.

Compliant: Yes

Article 25: Use of Closed Circuit Television (CCTV)

CCTV was not used inside the approved centre.

Compliant: Not applicable

Article 26: Staffing

The HSE policies on recruitment, selection and vetting of staff applied. A record of staff on duty and in charge of the centre was kept.

The following tables provide a summary of the current unit staffing levels.

Unit 1

STAFF TYPE	DAY	NIGHT
Nurse	4 + 1 CNM2	3
Household	2	0
Occupational therapy	2.0 (3.5 days a week)	–

Continuing Care (per ward)

STAFF TYPE	DAY	NIGHT
Nurse	4/5	2
Household	1.5	0
Occupational therapy	1 session a week	–

Two basic grade occupational therapy posts had been appointed to the hospital since November 2007. The posts were spread across acute and continuing care. Nurse numbers were allocated to continuing care wards based on dependency levels. A number of staff had attended training days during the year and staff had access to a variety of courses run by the HSE Dublin North East. The staff reported that they had received training in the Mental Health Act 2001.

Compliant: Yes

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

SECLUSION

The seclusion register was reviewed and cross-checked with the clinical files of a number of residents.

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	Part 19 of the form in the seclusion register was not signed by a registered medical practitioner in a number of instances. In one file, the record of examination was not entered in the clinical file. Alternatives to the use of seclusion considered were not always documented.
3	Patients' dignity and safety	Compliant
4	Monitoring of the patient	Compliant
5	Renewal of seclusion orders	Compliant
6	Ending seclusion	Compliant
7	Facilities	Access to toilet facilities was away from the seclusion area and necessitated going through the dormitory area. There were plans to rectify this by extending the whole ward into the soon-to-be-vacant next ward and constructing a new seclusion facility. Funding for this had not so far been approved.
8	Recording	Compliant
9	Clinical governance	A policy was in place. An audit had been completed on the use of seclusion and adherence to the Rules.
10	Staff training	Compliant
11	CCTV	There was no CCTV
12	Child patients	Children were not admitted to this unit

Breach: Section 2, Section 7

Compliant: No

ECT

ECT was no longer administered in the hospital. All equipment had been removed from the facility.

Compliant: Not applicable

MECHANICAL RESTRAINT

The service reported that it did not use any form of mechanical restraint. A policy stating that mechanical restraint was not used by the service was sent to the Inspectorate.

SECTION	DESCRIPTION	COMPLIANCE REPORT
21	Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour	<p>Continuing Care: A number of residents had been prescribed bed rails. This was documented in the file.</p> <p>Admission ward: A written record was maintained in the clinical file stating that cot sides were used at night and a Posey belt during the day. Reasons for, and duration of usage were recorded.</p>

Compliant: Yes

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	Clinical practice forms were not completed [Section 2.8].
3	Resident dignity and safety	Compliant
4	Ending physical restraint	Compliant
5	Recording use of physical restraint	Compliant
6	Clinical governance	A physical restraint management policy was implemented 1 June 2007, for review September 2009. An annual report on the use of physical restraint was provided.
7	Staff training	Compliant
8	Child residents	No children were admitted to the unit.

Breach: Section 2.8

Compliant: No

ADMISSION OF CHILDREN

The centre had no admissions of children. Any children who required admission were admitted to the Department of Psychiatry, Our Lady's Hospital, Navan.

Compliant: Not applicable

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	The service reported that it was reporting all deaths in compliance with the code.
3	Incident reporting	There was a system for recording, reporting and learning from incidents. Incidents were discussed at a bi-monthly health and safety meeting. Staff had recent risk management training. An overall risks profile was being collated.
4	Clinical governance	The risk management policy covers Section 4.

Compliant: Yes

ECT FOR VOLUNTARY PATIENTS

ECT was no longer administered in the hospital. All equipment had been removed from the facility.

Compliant: Not applicable

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

Continuing Care: One resident was detained under the Mental Health Act 2001. All the necessary forms were in order and recorded in the file.

Compliant: Yes