

Report of the Inspector of Mental Health Services 2008

HSE AREA	HSE Dublin North East
CATCHMENT	North Dublin
MENTAL HEALTH SERVICE	North Dublin
APPROVED CENTRE	St. Joseph's Intellectual Disability Services
NUMBER OF UNITS OR WARDS	13
UNITS OR WARDS INSPECTED	Dún na Rí St. Claire's St. Fiachra's Dunhaven
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	172
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	28–29 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.

The acting director of nursing and the CNM2s on the units inspected were interviewed. A feedback meeting was facilitated with medical, nursing and management staff.

DESCRIPTION

St. Joseph's Intellectual Disability Services provided in-patient care for 172 residents in 13 units, with a wide range of ages and length of stay in the hospital. There were three main care groups: care of the elderly, challenging behaviour or dual diagnosis, and general intellectual disabilities. Care was provided by 251 nurses, 207 health care assistants and two consultant psychiatrists. Each resident had a named consultant psychiatrist and key nurse. A large number of other staff with varied teaching and social care backgrounds provided day programmes. The staff have worked to develop person-centred care, have developed initiatives that reduce the need for seclusion and restraint, and have used research to influence local clinical practice. Recommendations from previous reports have always been acted on and there was a determined effort to continually improve the quality of care.

The shortage of health and social care professionals has been a barrier to creating other options for residents in the provision of care and previous attempts to recruit staff have failed. It was reported that six posts had been identified for priority filling. The posts were to be linked to professional groups based in the wider Primary Community and Continuing Care (PCCC) structure.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
St. Claire's	20	16	Intellectual disability team
Dún na Rí	20	19	Intellectual disability team
St. Fiachra's	19	16	Intellectual disability team
Hillview	20	18	Intellectual disability team
Dunhaven	14	11	Intellectual disability team
Fernlodge	6	6	Intellectual disability team
Rushbrook	16	12	Intellectual disability team
Ashlea	20	14	Intellectual disability team
St. Vincent's	8	8	Intellectual disability team
Fáilte	7	5	Intellectual disability team
La Vista	20	15	Intellectual disability team
St. Joseph's	19	16	Intellectual disability team
Tara Unit	19	11	Intellectual disability team

Many of the units were unsuitable for purpose. The completion of 10 six-bed bungalows before year end was an exciting development for the residents and staff, offering an opportunity to create home environments for individuals as well as new day care areas. There was a continued need however to maintain the remaining units to an acceptable standard until closure. A ring-fenced budget was required.

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. *The approved centre should introduce an individual integrated care plan for each resident.*

Outcome: The service continued to provide nursing and medical care. A pilot project of integrated medical and nursing care plans had been commenced on a number of wards. The results of this pilot study were being addressed and integrated care plans were due to be rolled out to all other wards. It was reported that posts in psychology, occupational therapy, social work, physiotherapy and dietetics will be advertised in the near future. The nursing care plans were comprehensive and regularly reviewed.

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

Outcome: The service provided a range of activities and educational programmes for residents. Information regarding outcomes and progress was recorded in the clinical file and linked to the individuals care plan. Since the last inspection a temporary building had been obtained for the residents of Dún na Rí, which facilitated activities for these residents. This was a positive development.

3. *The outstanding maintenance work for all units should be prioritised and completed as soon as possible.*

Outcome: This remained a problem. It was reported that some improvements had been made to units but the budget for maintenance was small. Present capital funding was being directed to the completion of ten new bungalows.

4. Resources should be made available for Dún na Rí in order to address the number of residents and then the lack of therapeutic activities on the unit.

Outcome: A temporary building to facilitate activities had been obtained.

5. The complaints procedure should be displayed in a prominent position in each unit.

Outcome: This was achieved in full. A new information booklet had been produced for the service. It clearly outlines the complaints procedure in written format and pictures. The procedure was on display in each unit inspected.

6. Staff should be provided with additional training in the use of snoezelen multisensory equipment.

Outcome: This was achieved. One day training had been completed for a number of staff. It was planned to provide an additional training day.

MDT CARE PLANS 2008

Care plans were nurse-led and there were medical plans. Each resident had a comprehensive assessment. The introduction of integrated medical and nurse care plan on some wards was a welcome development. Each plan was signed by the key nurse and medical staff. All were typed and in the clinical file. It should be widened to include all residents. The staff who facilitated the day programmes were recording outcomes and progress in the clinical files. The absence of health and social care professionals was an unmet need. This deficit was not always recorded.

GOOD PRACTICE DEVELOPMENTS 2008

- A new information booklet developed by the staff and residents was introduced. It was in plain English and used pictures to aid understanding.
- A detailed research project was jointly undertaken on site by the Centre for Nurse Education and the Nurse Practice Development Unit (NPDU) with the staff to determine the nurse to care staff ratio based on client dependency levels. This was a unique project that was currently work in progress. The outcome will influence the future configuration of the service, including the new streetscape development on campus and associated staffing levels. It provides a clear benchmark that will be reviewed as needs change.
- A review of the type and duration of diagnosis had commenced. It was hoped that all residents will have a diagnosis using the index for intellectual disability.
- The rates of seclusion had fallen for the second year. Records of episodes were kept on the ward.
- Residents on Dún na Rí had access to new space for activities based on the ward.
- A new emergency crash system was introduced.
- The purchase of one new bungalow in Julianstown for residents.

SERVICE USER INTERVIEWS

Residents spoke to the Inspectorate during the two-day inspection, though none of them formally requested a meeting.

**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 devised by his or her multidisciplinary team (MDT). The pilot project must be extended to all residents.
2. The recruitment of the six identified health and social care professional posts must be progressed and completed.
3. Each resident must have a six-monthly physical examination. A system should be put in place to ensure full compliance.
4. The new bungalows should be staffed and opened on completion.
5. There must be funds available to provide ongoing maintenance to the remaining units until they close.
6. All staff must have training in crisis prevention intervention (CPI) on a regular basis, in compliance with the code of practice.
7. The advocacy service should be extended and further developed.

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 28–29 JULY 2008

Article 6 (1-2) Food Safety

Information was submitted to the Inspectorate team that demonstrated compliance.

Compliant: Yes

Article 13: Searches

The service had a signed policy on searching and finding illicit substances in line with the requirements of this Article.

Compliant: Yes

Article 15: Individual Care Plan

Each resident had a comprehensive nursing care plan and medical treatment plan. The majority of nursing and medical files were maintained separately. A pilot scheme had been implemented using integrated notes for a number of residents. These had individual integrated care plans completed by nursing and medical staff. There were plans to advance this throughout the campus. The integrated care plans would be enhanced by the recruitment of other disciplines. It was subsequently reported that a full MDT had been recruited and would take up post in January 2009.

Breach: Not all of the residents in the units inspected had individual integrated care plans, as defined in the Regulations [Article 15].

Compliant: No

Article 16: Therapeutic Services and Programmes

The service had no occupational therapist, social worker or clinical psychologist and this limited the range of therapeutic services that could be provided for residents. Residents attended the programmes in the day services area. Formal written reports were kept in the clinical files. Programmes were facilitated by staff, including Montessori teachers, a PE teacher, and other instructors. The residents of Dún na Rí had a temporary building where they can partake in activities off the unit. A snoezelen multisensory room was available and staff were now trained in its use. Not all residents had integrated care plans, but those residents who had one had their therapeutic services and programmes linked to these care plans.

Breach: Article 16 (1)

Compliant: No

Article 17: Children's Education

The approved centre was for adults and did not admit children.

Compliant: Not applicable

Article 18: Transfer of Residents

The service was compliant.

Compliant: Yes

Article 19 (1-2): General Health

A GP attended the service daily. All the residents had a physical examination carried out by the GP in April 2008. It was reported that a six-monthly physical would be completed in October 2008. The service used a form for recording the annual examinations but the date of the examination was not always recorded. There was access to chiropody, dietetics, ophthalmology and dental health. All residents had access to the general medical services at Beaumont Hospital.

St. Claire's: There was no access to a physiotherapist and this was an unmet need for some of the residents. The female residents were offered a breast check appointment.

Dún na Rí: The clinical files of two residents were inspected. In one clinical file the sheet entitled 'Annual Physical Examination 2008' had a physical examination documented but the date section had not been filled. The previous physical examination had been completed in 2007. Photographic evidence was taken. In the other clinical file the physical examination had been completed on 5 April 2008 and the one prior to that had been completed on 11 June 2007. It was subsequently reported that they were all up to date.

Breach: Residents did not have six-monthly physical examinations [Article 19 (1)(b)].

Compliant: No

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

The service had developed a client information booklet. The design of the booklet was aimed at the resident's capabilities and was excellent. There was clear signage and the use of pictures to assist understanding. Information on medication and diagnosis was provided as needed to residents and their families. An advocate was available to some residents and contact details were in the booklet. This service was being developed further. The Friends of St. Joseph's parents and relatives group was working with the staff and working to provide funding.

Compliant: Yes

Article 21: Privacy

The service worked towards ensuring privacy for all residents. Where bed screens were not provided in one area of St. Claire's Ward, mobile screens were used.

Compliant: Yes

Article 22: Premises

Overall, the building was in a poor state of repair. An ongoing maintenance programme was in place and a number of wards had been painted since the last inspection. A new streetscape development of ten bungalows was at an advanced stage and was due for completion in December 2008. This was intended to allow the transfer of 60 residents to new purpose-built accommodation and to allow the reconfiguration of the rest of the service and the closure of a number of unsuitable areas.

Breach: A number of the wards were in a poor state of repair.

Compliant: No

Article 26: Staffing

Nursing staff, care staff and medical staff formed the core team. There was input in the clinical file from members of the day services. A chiroprapist, dentist, speech and language therapist and dietician were available when requested. The speech and language therapy and dietetics services were based in Beaumont Hospital. There was no access to physiotherapists.

The skill mix of staff was not sufficient to meet the assessed needs of the residents. The service had no social workers, occupational therapists and psychologists. It was reported that six posts had been identified and the recruitment process had begun. The six posts consisted of an occupational therapist, social worker, clinical psychologist, dietician and physiotherapist. It was reported that staff had been recruited and that these posts would be in place from January 2009.

The service had initiated an assessment of nursing to care staff levels based on a dependency scale. The results of this research were informing practice.

Breach: There were no occupational therapists, social workers or clinical psychologists attached to the service.

Compliant: No

Article 28: Register of Residents

The service had a computerised version of schedule 1 in place.

Compliant: Yes

Article 29: Operating policies and procedures

The policies and procedures were developed by the Nurse Practice Development Unit in conjunction with staff. The nurse practice officer had responsibility for reviewing policies in a timely manner

Compliant: Yes

Article 31: Complaint Procedures

The service had logged four complaints. The display of the complaint procedure in all units had raised the number of complaints received. All complaints were reviewed by the service manager.

Compliant: Yes

Article 32: Risk Management Procedures

There was a clinical risk management policy. In the clinical files examined, residents had an individual risk assessment incorporated into their care plans. The incident report book was inspected. Details of these incidents had been entered into the STARS Web tracking system.

There were no formal arrangements to learn from serious or untoward incidents. It was agreed by the senior management team that this would be incorporated into the agenda of the senior management team meeting [Article 32 (2)(d)].

Breach: Article 32 (2)(d)

Compliant: No

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

SECLUSION

A marked reduction in the use of seclusion was highlighted in the previous year's report and the rates of seclusion continued to fall in the current year. The seclusion register was up to date and the required documentation was in place. Families were consulted and their expressed preference about family notification of seclusion was taken into account. The clinical files of a number of residents who were subject to an amendment of Rule 2.5 of the Rules Governing the use of Seclusion were examined.

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	Patient dignity and safety	Compliant
4	Monitoring of the patient	Compliant
5	Renewal of seclusion orders	Compliant. In the clinical files examined, there was evidence that the length of time of the residents' stay in seclusion was short.
6	Ending seclusion	Compliant
7	Facilities	Compliant. Consideration might be given to the use of a more suitable waterproof fabric in the walls and floor of the seclusion room in Dunhaven Ward.
8	Recording	Compliant
9	Clinical governance	Compliant. There was a written policy. Evidence that staff have read and understood the policy was kept on each unit.
10	Staff training	Compliant. Information was sent to the Inspectorate regarding training of instructors and training of staff.
11	CCTV	Compliant
12	Child patients	Not applicable

Compliant: Yes

ECT

The service did not have an ECT facility and no resident was in receipt of ECT.

Compliant: Not applicable

MECHANICAL RESTRAINT

It was reported to the Inspectorate that mechanical restraint was not used

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Rules for the Use of Mechanical Restraint.

SECTION	DESCRIPTION	COMPLIANCE REPORT
21	Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour	<p>St. Claire's and St. Fiachra's: A number of clinical files were reviewed where cot sides, lap belts, groin restraints or Posey gloves were used. The documentation was in order. A form was used to record the restraint in use, its purpose, who had used it, and the duration of usage. The clinical files reviewed showed evidence of regular review and prescription of restraint by the consultant psychiatrists.</p> <p>Dún na Rí: It was reported to the Inspectorate mechanical restraint for enduring self-harm behaviour was not used.</p>

Compliant: Yes

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

PHYSICAL RESTRAINT

Dún na Rí: It was reported to the Inspectorate that physical restraint was not used.

Dunhaven: The clinical file of one resident who had been physically restrained was inspected. The physical restraint register was inspected.

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	Compliant
7	Staff training	Compliant. It was reported to the Inspectorate that a training programme was in place for all staff.
8	Child residents	Not applicable

Compliant: Compliant

ADMISSION OF CHILDREN

The centre did not admit children.

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	Compliant
3	Incident reporting	Non-compliant. The incident report book was inspected. Details of these incidents had been entered into the STARS Web tracking system. There were no formal arrangements to learn from serious or untoward incidents. The senior management team agreed to incorporate this into the agenda of the senior management team meeting.
4	Clinical governance	Compliant

Breach: Section 3.1(2)(d)

Compliant: No

ECT FOR VOLUNTARY PATIENTS

The service did not have an ECT facility and no resident was in receipt of ECT.

Compliant: Not applicable

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

There were no detained patients or children in the service.

Compliant: Not applicable