

# Report of the Inspector of Mental Health Services 2008

<b>HSE AREA</b>	HSE South
<b>CATCHMENT</b>	North Lee
<b>MENTAL HEALTH SERVICE</b>	North Lee
<b>APPROVED CENTRE</b>	St Michael's Unit, Mercy Hospital
<b>NUMBER OF UNITS OR WARDS</b>	2
<b>UNITS OR WARDS INSPECTED</b>	Acute Unit Sub-acute Unit
<b>NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED</b>	50
<b>CONDITIONS ATTACHED TO REGISTRATION</b>	No
<b>TYPE OF INSPECTION</b>	Announced
<b>DATE OF INSPECTION</b>	17 June 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 met with residents, the director of nursing, the CNM3, the CNM2s on each of the units, the clinical director and representatives of clinical psychology, occupational therapy and social work. A feedback meeting was facilitated following the inspection.

### DESCRIPTION

St. Michael's Unit was located in the Mercy Hospital. It provided acute in-patient care for a total population of 167,536. The population was served by five sector teams and one home care team. There were large areas of high deprivation and Revitalising Areas by Planning, Investment and Development (RAPID) areas in the catchment. The service had no dedicated beds for the provision of care to individuals with dementia. This had placed a burden on the use of acute beds for this purpose.

<b>WARD</b>	<b>NUMBER OF BEDS</b>	<b>NUMBER OF RESIDENTS</b>	<b>TEAM RESPONSIBLE</b>
Acute Unit	18	18	general adult team
Sub-acute Unit	32	32	general adult team

On the day of the inspection, there were six residents inappropriately placed in the acute unit who required specialised dementia care. The unit was located on the first floor with no identified reception area or garden.

## RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. *The service must develop and implement the outstanding policies, procedures and protocols that are required by the Regulations. Policies must reflect local practice.*

**Outcome:** All the policies had been developed and reflected local practice. On the day of the inspection, they were in the final stages of signing by the management team. Outstanding policies on searches and risk management must be sent to the Inspectorate team.

2. *The provision of CCTV must be in accordance with Article 25. This must be rectified immediately and alternatives put in place to manage issues related to observation on the unit.*

**Outcome:** This matter had been resolved in full.

3. *All the sector teams should be fully staffed.*

**Outcome:** There were no improvements in staffing levels. Since 31 December 2007 the teams had lost posts under the HSE recruitment freeze. This was particularly acute in clinical psychology posts. An unmet need for speciality teams in psychiatry of later life and rehabilitation was not progressed.

## MDT CARE PLANS 2008

The service continued to use the multidisciplinary care planning process that it had implemented last year. This was based initially on formal nursing and medical assessments. There was no record of who attended team meetings and therefore no documentation of the range of disciplines that had contributed to the care plan.

Of concern to the Inspectorate was the fact that although team meetings were held weekly and staff reported that care plans were reviewed at these meetings, the care plan documentation had not been updated in some of the clinical files reviewed. This was a step back from the progress the service had made in relation to individual care planning at the time of the previous year's inspection. The care planning process could be enhanced and further developed by including a record of those attending team meetings to document the range of professionals available to contribute to the care plans, documenting unmet need, and making a copy of the care plan available to the resident.

## GOOD PRACTICE DEVELOPMENTS 2008

- A risk screening tool had been developed.
- A number of nurses had commenced post graduate training.
- The unit had facilitated a music therapy student from University of Limerick. The clinical staff reported that this was very successful.
- There was a weekly meeting between the advocate and some of the clinical staff.
- A liaison nurse had been appointed to a GP practice as part of a pilot scheme.

## SERVICE USER INTERVIEWS

A resident asked to meet with the Inspectorate. Concerns were expressed by the resident regarding an impending tribunal. These concerns were reported to the nurse in charge of the unit and dealt with.

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

1. Each resident must have a care plan that is regularly reviewed and updated.
2. All sector teams must be appropriately staffed to meet the needs of the population served.
3. There must be a clear operation plan to provide speciality services in rehabilitation and psychiatry of later life.

## **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 17 JUNE 2008**

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

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Information was submitted on food safety procedures prior to the inspection.

**Compliant:** Yes

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

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A policy was submitted.

**Compliant:** Yes

#### **Article 11 (1-6): Visits**

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A localised policy was submitted.

**Compliant:** Yes

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

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A localised policy was submitted.

**Compliant:** Yes

#### **Article 13: Searches**

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The policy on searches was forwarded to the Inspectorate as requested.

**Compliant:** Yes

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

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A localised policy was submitted.

**Compliant:** Yes

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

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The same system was in place from the previous year. However in some of the files reviewed there was no record that the care plan had been reviewed for a number of weeks. The resident did not attend their review. The care planning process could be enhanced and further developed by including a record of those attending team meetings to document the range of professionals available to contribute to the care plans, documenting unmet need, and making a copy of the care plan available to the resident.

**Breach:** Not all care plans were reviewed and updated by the multidisciplinary team.

**Compliant:** No

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

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There were two programmes available for residents, occupational therapy and nurse therapy. A weekly meeting took place between the two staff groups, and residents were allocated to the programme depending on need. In addition, residents had an individual occupational therapy programme. The unit had a good range of equipment and facilities in place. The programmes were linked to an individual care plan where they were reviewed and updated.

**Breach:** Not all files reviewed had therapeutic services linked to an individual care plan [Article 16 (1)].

**Compliant:** No

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

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Appropriate educational services were made available to children who were admitted to the approved centre.

**Compliant:** Yes

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

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There was a transfer sheet in place for internal transfers within the hospital complex. There was a policy available on the day that reflected transfer procedure for detained patients. The policy must reflect transfer procedure for all residents.

**Breach:** Article 18 (2)

**Compliant:** No

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

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It was reported that a full physical examination was completed on admission by the NCHD. Access to national screening programmes was arranged as needed. The staff reported that the emergency team was called in the event of a medical emergency. There was also an emergency trolley on the ward. The ward used the hospital-wide policy on responding to emergencies. The notes examined showed evidence of regular physical reviews.

**Compliant:** Yes

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

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An information booklet was available to residents. Written information detailing the residents MDT was not available. Staff informed the resident verbally who their team was. There was no written information available on the residents' diagnosis. The Irish Advocacy Network visited that ward weekly. There was a policy available on the day that reflected local practice.

**Breach:** Article 20 (1)(c)

**Compliant:** No

### **Article 21: Privacy**

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There were two single rooms. All residents had a curtain around their bed area.

**Compliant:** Yes

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

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All medication was ordered from the Mercy Hospital. Prescriptions were written on a card index system. Medication was stored in a locked clinical room and administered by two nursing staff. A clinical pharmacist attended the ward several times a week. A policy was available on the day.

**Compliant:** Yes

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

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A policy was submitted. The difficulties outlined last year had been addressed.

**Compliant:** Yes

### **Article 26: Staffing**

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All staff were recruited through the central HSE system. It was reported that the occupational therapy, psychology and social work staffing levels were insufficient to provide for the assessed needs of residents [Article 26 (2)]. A significant number of residents were elderly. There was no specialist team for these residents [Article 26 (2)].

The ward had access to a dietician, pharmacist and physiotherapist. There was a CNM3 on duty from Monday to Friday and an assistant director of nursing on duty over a seven-day roster. It was reported that all staff had received training in the Mental Health Act 2001. A number of nursing staff were funded to attend further education courses. There was a small library on the ward for use by staff.

**Breach:** Article 26 (2)

**Compliant:** No

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

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Records relating to food safety, health and safety, and fire inspections were inspected on the day.

**Compliant:** Yes

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

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The register was incorporated into the admission sheet. It contained all the sections under Schedule One.

**Compliant:** Yes

**Article 29: Operating policies and procedures**

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The service reported that all policies were under review by a multidisciplinary group and review dates were set for 2009.

**Compliant:** Yes

**Article 31: Complaint Procedures**

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The service followed the HSE complaints procedure. The complaints procedure was displayed in the unit.

**Compliant:** Yes

**Article 32: Risk Management Procedures**

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A copy of the risk management policy was sent to the Inspectorate. There were individual policies in place to address the risks identified in this Article. There was a set system in place to review and monitor incidents on the ward. A record of incidents was made available to the Inspectorate.

**Compliant:** Yes

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

### SECLUSION

There were no dedicated facilities on the ward on the day of the inspection and staff reported that seclusion was not used. A policy confirming this was sent to the Inspectorate.

**Compliant:** Not applicable

### ECT

The ECT register was reviewed. No detained patients had received ECT since January 2008.

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	Non-compliant. A new machine had been purchased. Up-to-date protocols were not displayed [Section 10.1].
11	Staffing	Compliant
12	Documentation	Not applicable
13	ECT during pregnancy	Not applicable

**Breach:** Section 10.1

**Compliant:** No

## MECHANICAL RESTRAINT

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Staff reported that mechanical restraint was not used in this service. A policy confirming this was sent to the Inspectorate.

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	<b>Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour</b>	The service was advised to clarify the procedure for recording mechanical restraint under Part 5 of the Rules in the policy. The Inspectorate wrote to the service following the inspection seeking clarification on use of a Kirton chair but no response was received.

**Breach:** Section 18.1 [Part 5 (21.4)]

**Compliant:** No

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

### PHYSICAL RESTRAINT

The physical restraint register and a number of clinical files were reviewed. The standard of documentation was excellent.

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	Non-compliant. The policy had not been updated annually [Section 6.1(d)]. There was no annual report on the use of physical restraint in the centre [Section 6.3].
7	Staff training	Non-compliant. It was reported that 100 staff had been trained in crisis prevention intervention (CPI) techniques. The frequency of training was unclear. It was reported by the clinical staff that this issue was unresolved at national level. Staff were not receiving training or refresher courses in restraint techniques and therefore the record of staff training was not up to date.
8	Child residents	Not applicable

**Breach:** Section 6.1(d), Section 6.3, Section 7.1, and Section 7.2.

**Compliant:** No

**ADMISSION OF CHILDREN**

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	<b>Admission</b>	<p>The approved centre was used for the admission of children. There was an admission policy. All children were admitted under the general adult team. Age-appropriate facilities were not available [Section 2.5(b)].</p> <p>Every effort was made to protect the safety of the child. Children had one-to-one nursing provided as required. Staff had completed children first training and police vetting. The centre was unable to provide segregated sleeping and bathroom areas [Section 2.5(d)(iii)].</p> <p>Staff train relating to the care of children was compliant. Educational arrangements were made if appropriate. It was reported that length of stay was very short.</p> <p>There were no age-appropriate advocacy services available nationally [Section 2.5(g)].</p> <p>The child’s understanding of the explanation they received of their rights and of information about the unit was not documented in one clinical file reviewed [Section 2.5(h)].</p> <p>There was a standard procedure on risk assessment applied to all residents.</p> <p>Advice from the child and adolescent mental health service was not available.</p> <p>Visiting arrangements were compliant. Policies on family liaison, parental consent and confidentiality must be submitted to the Inspectorate team [Section 2.5(l)].</p> <p>Notification of child admissions to the MHC was compliant. Three children had been admitted since the first quarter of the year.</p>
3	<b>Treatment</b>	Compliant
4	<b>Leave provisions</b>	Compliant

**Breach:** Section 2.5(b), Section 2.5(d)(iii), Section 2.5(g), Section 2.5(h), and Section 2.5(l)

**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. The risk management policy did not identify the risk manager or person with responsibility for risk management within the mental health service. A senior risk management group was referred to, but the composition of that group was not documented in the policy

**Compliant:** No

## ECT FOR VOLUNTARY PATIENTS

The ECT register and a number of clinical files of were reviewed.

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	Non-compliant. A new machine had been purchased. Up-to-date protocols were not displayed [Section 9.1].
10	Staffing	Compliant
11	Documentation	Compliant
12	ECT during pregnancy	Not applicable

**Breach:** Section 9.1

**Compliant:** No

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

Section 60 requirements were in order in the clinical files reviewed.

**Compliant:** Yes