Report of the Inspector of Mental Health Services 2008

HSE AREA	HSE Dublin North East
CATCHMENT	Dublin North Central
MENTAL HEALTH SERVICE	Dublin North Central
APPROVED CENTRE	St Vincent’s Hospital, Fairview
NUMBER OF UNITS OR WARDS	5
UNITS OR WARDS INSPECTED	St. Catherine’s Ward St. Louise’s Ward
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	87
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	24 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.

DESCRIPTION

St. Vincent’s Hospital provided acute care, continuing care, rehabilitation and psychiatry of old age. The hospital was a partner with the HSE in the provision of in-patient services for the population of Dublin North Central. Alternatives to in-patient care were limited by poorly resourced multidisciplinary general adult teams and the lack of team-based day hospitals and home care services. The hospital also provided private in-patient care in St. Mary’s Ward.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
St. Louise’s	30	23	General Adult
St. Catherine’s	21	17	Various teams
St. Mary’s	9	9	General Adult
St. Teresa’s	21	21	Rehabilitation
Psychiatry of Later Life	6	6	Psychiatry of Later Life

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. Multidisciplinary care plans should be in place on each ward.

Outcome: It was reported by the senior management team that MDT care plans had been implemented on each ward. A number of files were reviewed during the course of the inspection. Although a number of files contained a sheet headed “integrated care plan”, these were not completed and did not reflect an MDT approach to care.

2. Multidisciplinary teams should function in accordance with national mental health policy. This includes regular multidisciplinary team meetings in each unit and in the community.

Outcome: The core teams were not sufficiently resourced to facilitate regular team meetings. There were weekly ward rounds attended by nursing and medical staff.

MDT CARE PLANS 2008

There were no MDT care plans in the hospital. The nursing staff had begun to research an MDT care plan without the inclusion of health and social care professionals. The core membership of the teams was inadequate to meet the needs of the population served. Team working remained an aspiration in many of the sectors.

GOOD PRACTICE DEVELOPMENTS 2008

Organisational:

- A heads of discipline group was established and included the regional advocate.
- A principal clinical psychologist was appointed.
- Formal links had been established with a named carer’s group.
- Plans for six beds for children aged 16–18 years had been progressed. Construction work was due to be completed by the end of July. Recruitment of the necessary staff had commenced.

St. Catherine’s Ward:

- The choice and variety of food had been improved. A healthy eating programme had been introduced.
- The nursing staff were developing a standard pack for nursing students on the ward.
- All staff had been trained in CPR.

SERVICE USER INTERVIEWS

A number of residents asked to meet with the Inspectorate on St Louise’s Ward. They were all generally satisfied with their care. Two residents requested more information about the role of the MHC. This was provided.

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

1. The service must put in place systems to meet the requirements of the Regulations, Rules and Codes of Practice under the Mental Health Act 2001.

2. Residents must have individual care plans based on their assessed needs. There must be equal access to all disciplines based on need.

3. The community mental health teams must be adequately resourced to meet the needs of the serviced population.

4. All disciplines should be involved in the development and implementation of MDT care plans.

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 24 JUNE 2008

Article 6 (1-2) Food Safety

The service reported that it was compliant with this Article. A food safety policy was submitted.

Compliant: Yes

Article 15: Individual Care Plan

A new integrated care plan was introduced following the last inspection. It was inspected on both wards.

St. Catherine's Ward: Four files were reviewed, one from each of the admitting teams. The integrated care plan was located in the front of the medical chart. In the files reviewed, there was evidence that review dates had not been adhered to, there was no link made to the nursing care plan or the activities programme provided on the ward by a clinical nurse specialist.

St Louise's Ward: Four files were reviewed from different sectors. Two files contained the integrated care plan. The care plans did not contain a composite set of goals for the resident, it was unclear who attended the team meeting/review and the plan did not specify which member of the MDT was involved. Each resident had a nursing care plan which was in a separate file. It was unclear how involved the residents were in their care plans.

Breach: Article 15

Compliant: No

Article 16: Therapeutic Services and Programmes

St. Catherine's Ward: The residents had access to nursing, medical and physiotherapy staff on a regular basis. A chiropodist and geriatrician attended the ward as required. Residents can be referred to the clinical psychologist in the hospital. Due to the limited resources on the community mental health teams there was no access to occupational therapy or social work. The residents were referred to the Mater hospital for other specialises as required. Needs were not recorded in the individual care plans.

An activities programme was facilitated on the ward by a clinical nurse specialist. A record was kept in the nursing file. There was no linked record with an individual care plan.

St Louise's Ward: Ward-based nursing staff facilitated a ward-based programme. There was a varied group programme and a number of guest speakers from various mental health organisations frequently visited the ward. There was no linked record with an individual care plan.

Breach: Article 16 (1)

Compliant: No

Article 17: Children's Education

On the day of the inspection there was a child in the hospital. The educational needs of the child were being met. There was a policy on education dated September 2007.

Compliant: Yes

Article 18: Transfer of Residents

The service was compliant.

Compliant: Yes

Article 19 (1-2): General Health

There was a policy in place.

St. Catherine's Ward: There was access to junior medical staff and a consultant geriatrician on referral, 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. No resident met the criteria for current national screening programmes.

St Louise's Ward: There was access to junior medical staff and a physiotherapist. If the need arose residents accessed a general hospital in the area. In the files reviewed there was evidence that all general health examinations had been completed in the last six months.

Compliant: Yes

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

St. Catherine's Ward: Information was provided verbally to the residents. There was an information leaflet detailing the requirements under the article. The Irish Advocacy Network (IAN) visited the ward on request only. Details were posted on the ward. A number of voluntary agencies visited and provided social activities. It was reported that information on medication was provided on request. The ward had access to information on the internet.

St Louise's Ward: There was an information leaflet detailing the requirements under the article. The IAN visited the ward weekly. Details were posted on the ward.

Compliant: Yes

Article 21: Privacy

The service was compliant.

Compliant: Yes

Article 22: Premises

St. Catherine's Ward: A number of deficits from last year had been resolved. These included the provision of new male toilets, upgrading of the dining room and furniture and the painting of some areas. There was a programme in place to address the outstanding painting and maintenance. It was reported that this will commence in October. Specialised seating had been provided for two residents.

Breach: Article 22 (3)

Compliant: No

Article 26: Staffing

The HSE vetting standards applied to the service.

St. Catherine's Ward was staffed by health care assistant, domestic staff and nursing staff. There was access to a part-time physiotherapist on the ward. The medical staff visited the ward to review residents. It was reported that a new timetable was being developed. Due to inadequate resourcing of the community mental health teams there was no input from health and social care professionals onto the ward. There was provision for referral to the clinical psychologist. In St. Louise's Ward, there was access to health and social care professionals on some teams by referral.

The service was compliant with Sections 3, 4 and 5 of this Article.

Breach: Article 26 (2)

Compliant: No

Article 32: Risk Management Procedures

There was no comprehensive written risk management policy in place. The service acknowledged that this was a deficit. They reported that there are plans to recruit a risk manager and to be compliant with the Code of Practice.

Breach: Article 32

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**	Compliant
3	**Patients' dignity and safety**	Compliant
4	**Monitoring of the patient**	Compliant
5	**Renewal of seclusion orders**	Compliant
6	**Ending seclusion**	Compliant
7	**Facilities**	Compliant
8	**Recording**	Compliant
9	**Clinical governance**	Compliant
10	**Staff training**	Compliant
11	**CCTV**	Not applicable
12	**Child patients**	Not applicable

Compliant: Yes

ECT

No detained patient was in receipt of ECT on the day of the inspection and no file was reviewed.

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**	No file reviewed
5	**Prescription of ECT**	No file reviewed
6	**Patient assessment**	No file reviewed
7	**Anaesthesia**	No file reviewed
8	**Administration of ECT**	Compliant
9	**ECT Suite**	Compliant
10	**Materials and equipment**	Compliant
11	**Staffing**	Compliant
12	**Documentation**	Compliant
13	**ECT during pregnancy**	No file reviewed

Compliant: Yes

MECHANICAL RESTRAINT

The Inspectorate was informed that mechanical restraint was not currently used in any unit. There was a policy detailing the policy and procedure of the service. No file was reviewed.

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
14	**Orders**	Not applicable
15	**Patient dignity and safety**	Not applicable
16	**Ending mechanical restraint**	Not applicable
17	**Recording use of mechanical restraint**	Not applicable
18	**Clinical governance**	A policy was available.
19	**Staff training**	This information was not collected on the day. Evidence of compliance was requested but not received by the Inspectorate team.
20	**Child patients**	Not applicable
21	**Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour**	This was reviewed on St. Catherine's Ward. On the day of the inspection two residents were seating in belted chairs and one resident had a lap-top table. There was no prescription in the charts or the care plan [Section 21.4]. Evidence that this has been reviewed and documented was requested but not received by the Inspectorate team.

Breach: Section 19, Section 21.4

Compliant: No

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

PHYSICAL RESTRAINT

The service had implemented a policy on 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**	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
8	**Child residents**	Compliant

Compliant: Yes

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.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Admission**	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 available by arrangement with the local child and adolescent team. 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. A child was nursed in a single room. Educational arrangements were made if appropriate. There was a school on site. It was reported that length of stay was very short. There are no age-appropriate advocacy services available nationally. There was evidence in the file showing that the staff had explained the residents' rights and the function of the ward. There was a standard procedure on risk assessment applied to all residents. The policies specified in Section 2.5(l) were not submitted to the Inspectorate team. The centre was in compliance with Section 2.5(m). Four children had been admitted since the start of the year.
3	**Treatment**	A policy on parental consent was not submitted.
4	**Leave provisions**	This was documented in the file reviewed.

Breach: Section 2.5 and Section 3

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**	It was reported that all deaths were reported to the MHC.
3	**Incident reporting**	There was no effective system in place to implement Article 32 of the Mental Health Act Regulations.
4	**Clinical governance**	There was no risk management policy and procedure in place.

Breach: Section 3 and Section 4

Compliant: No

ECT FOR VOLUNTARY PATIENTS

One outpatient had recently received ECT. The file was 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**	Compliant
10	**Staffing**	Compliant
11	**Documentation**	Compliant
12	**ECT during pregnancy**	Compliant

Compliant: Yes

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

There were no detained patients on St. Catherine's Ward on the day of the inspection.

Section 60 was completed on detained patients in St Louise's Ward where appropriate.

Compliant: Yes