St. Aloysius Ward, Mater Misericordiae University Hospital

ID Number: AC0028

2018 Approved Centre Focused Inspection Report (Mental Health Act 2001)

St. Aloysius Ward
Mater Misericordiae University Hospital
Eccles Street
Dublin 7

Approved Centre Type:
Acute Adult Mental Health Care

Most Recent Registration Date:
25 September 2015

Conditions Attached:
None

Registered Proprietor:
Mr Gordon Dunne

Registered Proprietor Nominee:
N/A

Inspection Team:
Dr Susan Finnerty MCRN009711 Lead Inspector
Mary Connellan

Inspection Date:
7 February 2018

Inspection Type:
Focused Inspection

Previous Inspection Date:
28 February - 3 March 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
23 August 2018

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1.0 Introduction to the Inspection Process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to "visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate".

Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

On a focused inspection, the Inspector does not assess all regulations, rules, code of practice, and Part 4 of the 2001 Act. The focus of the inspection will be on specific legislative requirements, or parts of legislative requirements where it is determined that there may be a risk to the safety, health and wellbeing of residents and/or staff members.

Following the focused inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings and risk ratings, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.

2.0 Inspector of Mental Health Services – Summary of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

As Inspector of Mental Health Services, I have provided a summary of findings from the focused inspection of St. Aloysius Ward.

There had been specific concerns regarding the lack of staff for the delivery of therapeutic services and programmes in St. Aloysius Ward. This had been identified in the 2015 inspection, and all subsequent inspections. Following enforcement action, this focused inspection was carried out to ascertain whether plans to improve staffing and therapeutic activities had been implemented.

We found that, while the approved centre remained non-compliant with staffing, there was 0.5 WTE social worker in the approved centre. We also found that interviews for the recruitment of an occupational therapist (1 WTE) were to take place within two weeks, and that a senior psychologist (0.5 WTE) was due to commence in the approved centre in March 2017.

The provision of therapeutic services and programmes had been dependent on staffing. While the required posts were in the process of being filled, a clinical psychologist and psychology assistant from one of the sector teams had been facilitating a weekly psychology group. A four-week rolling programme for group therapeutic programmes and recreational activities had been developed and had partially commenced. Nursing staff facilitated aromatherapy groups, art groups, sleep hygiene and Cognitive Behavioural Therapy (CBT) informed skill groups. While these were timetabled, it was stated that these were dependent on the ward needs at the time and it was not clear whether these groups were taking place consistently.

Overall, there was evidence that the registered proprietor was addressing the non-compliance with staffing and therapeutic services and programmes. However, the approved centre remained non-compliant with these two regulations.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located in the original building of the Mater Misericordiae University Hospital, necessitating a walk through a general medical ward to gain access. The approved centre consisted of a long corridor, with rooms on either side. There was a large sitting/dining room, an activation room, and a relaxation room. There were bedroom and bathroom facilities, a nursing office and a multi-disciplinary meeting room. There was a visitors' room that was temporarily out of use at the time of inspection. The kitchen that had been closed for renovation works at the time of the 2017 inspection had been completed.

Renovations were ongoing at the time of inspection. Floor coverings in the corridor had been replaced and the walls in the corridors had been plastered and were being rendered for painting. Two rooms had been refurbished for offices. The visitors' room was being used by builders until works were completed.

The activation room while spacious was particularly cluttered. There was a bookcase with relevant evidence-based reading materials, an arts and crafts area, gym equipment, and various utensils about this room. There was an enclosed kitchenette in the room; this area required a deep clean, and was remedied on the morning of the inspection.

The relaxation room, which was identified as a potential multi-sensory room, was in need of refurbishment and modernisation. On the day of the inspection a disused seclusion bed was being stored in the room. This was not conducive to relaxation.

The day room/dining room was large and airy and there was a door with direct access to the garden space. This was only open at identified times and was always supervised by a member of staff. This garden had opened in the summer of 2017. Proposed exercise machines and an all-weather table tennis table had not yet been installed in the garden. The former smoking room, which had been located in the large sitting /dining room, was being renovated and was to become a small gym room. The day room had a large supply of DVDs and board games. There was a flat screen TV which on the day of inspection was noted to have poor reception. This was also noted in feedback from one of the residents in the community meeting minutes.

The resident profile on the first day of inspection was as follows:

Resident Profile	
Total number of residents	7
Number of detained patients	2
Number of Wards of Court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	0

3.2 Conditions to registration

There were no conditions attached to the registration of this approved centre at the time of inspection.

3.3 Governance

The CEO of the Mater Misericordiae University Hospital (MMUH) was the registered proprietor of the approved centre. There was an agreement to transfer governance responsibilities of St. Aloysius Ward to the HSE Dublin North City and County Mental Health Service.

There was an organisational chart and clear governance structures and processes in place. The HSE provided funding for the following resources: the sector consultant psychiatrists, seven of the seventeen nurses employed in the approved centre, and the clinical psychologist. MMUH funded ten nurses and the three consultant psychiatrists in liaison psychiatry, and it provided the structure of the approved centre and was responsible for its maintenance. The Clinical Director was employed by the HSE and worked between the HSE community Mental Health Services, St. Vincent's Hospital Fairview and the Mater Misericordiae University Hospital.

The approved centre had fortnightly meetings for a multi-disciplinary team (MDT) development group. This group comprised of representatives from the senior management team, assistant director of nursing, and personnel from both the HSE and the Mater Hospital. This committee had addressed and actioned items pertaining to the setting up a therapeutic programme in the approved centre. It was envisaged that when this work had progressed this committee would then comprise of the individuals responsible for the delivery of the service and programme.

4.0 Background

4.1 Reason for focused inspection

Since 2015, serious concerns have been formally raised in relation to St. Aloysius Ward, including inadequate staffing and inadequate therapeutic services. There was also lack of engagement from the service on ongoing non-compliances and failure to provide information requested. This evidenced a cycle of serious concerns identified and raised on inspection and inadequate responses received from the service.

Because of this, the approved centre was issued with a closure notice (proposal to remove approved centre from the Register of Approved Centres) on 10 August 2017. Representations from the registered proprietor in relation to the proposal were provided, which outlined staffing improvements that were in progress.

The approved centre attended a Regulatory Compliance Meeting on 14 September 2017, in which these issues were discussed. It was agreed that the service would provide further information, including detailed timeframes, in relation to how they would ensure the provision of an appropriate therapeutic programme to residents in line with their assessed needs. On the basis of the further information provided, the Mental Health Commission provided the service with the opportunity the service to implement their plans.

It was determined that a focused inspection would be undertaken to ascertain whether appropriate actions had been taken by the service to address the risks identified, following the September meeting.

4.2 Focus of inspection

The focus of the inspection was Regulation 16: Therapeutic Services and Programmes and Regulation 26: Staffing, determined in advance of inspection by the Commission's Regulatory Review Committee. This committee comprises of the Director of Standards and Quality Assurance, the Inspector of Mental Health Services and the Chief Executive of the Mental Health Commission.

Specific legislative requirements, or parts thereof, inspected as part of the focused inspection were as follows:

Regulation	Part (or full regulation)
Regulation 16: Therapeutic Services and Programmes	Evidence of implementation
Regulation 26: Staffing	Evidence of implementation

5.0 Focused Inspection Findings

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(1) The registered proprietor shall ensure that each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan.

(2) The registered proprietor shall ensure that programmes and services provided shall be directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident.

INSPECTION FINDINGS

A four-week rolling programme for group therapeutic programmes and recreational activities had been developed and had partially commenced. The timetable stated that the groups and activities could be flexible.

A goal-setting group, which was facilitated by the nursing staff, was held every Monday along with a community meeting group every Friday. The social worker had commenced a group, two weeks prior to the inspection, to be held each Thursday, and in preparation for this had also attended the community meeting. It was envisaged that the social worker would continue to attend the community meetings, facilitate a group themselves and had proposed to hold a walk-in clinic at identified times on a weekly basis.

It was timetabled that there would be a kitchen time/healthy eating group although this had not commenced.

A group titled *Alcohol and the Body* was also timetabled however this group was not operational at the time of inspection.

A psychologist and psychology assistant from one of the sector teams had been facilitating a weekly psychology group. This arrangement had concluded on the day of the inspection and was to be recommenced when the new psychologist joined the staff of the approved centre.

Nursing staff facilitated aromatherapy groups/art groups, sleep hygiene and Cognitive Behavioural Therapy (CBT) informed skill groups. While these were timetabled, it was stated that these were dependent on the ward needs at the time and that staff did not always document that the group had taken place. The inspector reviewed the record of groups that had taken place since 22nd January 2018. The record included recreationally focused activities such as garden time, a music group and recreational sports; however, they either had not taken place or staff had not recorded the number of attendances.

The pharmacist from the Mater services facilitated an information group once a month. This was evidenced in the attendance record. The pharmacist also attended the approved centre at least weekly and was instrumental in the process of medication reconciliation for each new admission. The pharmacist liaised with the non-consultant hospital doctors, and was involved with the nicotine replacement therapy (smoking cessation) prescribing.

Review of all individual care plans (ICP) evidenced an awareness of the responsibility of the multi-disciplinary team to document the residents assessed needs and persons responsible for facilitating or delivering same. The ICP template itself was pre populated and did not lend itself to the documentation of assessed needs clearly. This was recognised by staff and the ICP template was under review.

Nonetheless, it was evident that the teams were recommending the various groups and activities as needed to the resident, and where an assessment had been completed there were clear outcomes.

There was evidence that the service was addressing the requirement to ensure that there was an appropriate range of therapeutic services and programmes in accordance with the individual care plans. At the time of the inspection this requirement had not been met. The introduction of a 4-week flexible programme was a welcome addition although it was unclear what groups had actually been facilitated and what numbers of residents had attended. There was also a mix of both recreational and therapeutic activities on the timetable. This could be confusing or misleading for the resident. Some of the groups on this timetable had not commenced.

While the approved centre remained non-compliant with this regulation, there was some improvement since the previous inspection.

The approved centre was non- compliant with this regulation for the following reasons:

a) **The registered proprietor did not ensure that each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan, 16(1).**
b) **The registered proprietor did not ensure that programmes and services provided shall be directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident, 16(2).**

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.

(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.

(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.

(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.

(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.

(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

INSPECTION FINDINGS

There were two consultant led-teams composed of five consultant psychiatrists serving a bed capacity of 15.

There was an in-patient consultant psychiatrist as well as a consultant psychiatrist with responsibility for the community mental health services. This team had a social worker 0.5 Whole Time Equivalent (WTE) who had commenced in the approved centre two weeks prior to the inspection. The service was in the process of recruiting an occupational therapist and an occupational therapist assistant. A psychologist 0.5 WTE was due to commence in March.

There was also a liaison team with two consultant psychiatrists who had access to five beds. This team was fully resourced.

One other psychiatrist provided a service for the students in the Royal College of Surgeons in Ireland (RCSI), and had admitting rights to the approved centre for these students if they required inpatient treatment.

The approved centre had one assistant director of nursing, who worked Monday to Friday, with responsibilities in the community and liaison services also. There was a clinical nurse manager (CNM)2 who also worked Monday to Friday in the approved centre.

The complement of nursing staff was 17 WTE and on the day of the inspection, there were 4 nursing vacancies. Proportionally this was high, at just over 25%. All of these pertained to the Mater Service complement of staff. However, efforts were continuing to address this and advertisements had been placed in national newspapers and were on the Mater Hospital website. Vacancies were managed by over time inputs from the staff in the approved centre, from staff in Dublin North services and from regular agency staff. There were usually four staff nurses on duty each day and three at night. One of the night duty staff was always an agency nurse. The clinical nurse manager was additional to the three staff nurses on days; however, at times depending on the acuity and resident numbers there had been only three staff nurses on days.

On the day of the inspection the clinical nurse manager, two staff nurses, two fourth year intern nurses and two supernumerary student nurses, were present and on duty.

Training records pertaining to all the nursing staff and the social worker were reviewed. While not all mandatory training was fully up to date, training was ongoing and considerable improvements had been made since the inspection in 2017. For example, 100% healthcare staff were now trained in fire safety compared with 33% previously. There was further therapeutic management of violence and aggression (TMVA) training for the day post-inspection.

The following is a table of staff assigned to the approved centre on the day of the focused inspection:

Ward or Unit	*Staff Grade*	*Day*	*Night*
St. Aloysius	CNM2	1 Mon- Friday	0
	RPN	2	3
	Intern Nurse	2	0
	HCA	0	
	Occupational Therapist	0	
	Social Worker	0.5 WTE	
	Psychologist	0	

Please note: WTE= Whole Time Equivalent.

The approved centre was non-compliant with this regulation for the following reasons:

a) **The numbers and skill mix of staff was not appropriate to the assessed needs of residents, the size and layout of the approved centre, 26 (2).**