Mental Health Commission finds fourteen high risk ratings in two out of three mental health centres

Tuesday 17 December 2019: The Mental Health Commission (MHC) has today published three inspection reports from approved centres in Sligo/Leitrim, Dublin and Kilkenny which identified fourteen areas of high risk non-compliance in two of the three centres.

Commenting on the reports, Dr Susan Finnerty, Inspector of Mental Health Services, said: "It is disappointing to see compliance in an approved centre dis-improve year on year and areas remaining consistently non-compliant over three years, despite the Commissions guidance documents and judgement framework. This is in direct contrast to the very significant improvement in the compliance with regulations in St Gabriel's Ward in Kilkenny with a thirty percent increase since last year."

Sligo / Leitrim Mental Health In-patient Unit is a 32-bed acute adult mental health admission unit; 14-bedded female, 14-bedded male and a 4-bedded high-dependency ward, located on the outskirts of Sligo. The building dates from the 1930s and is unsuitable for providing a modern mental health service. Building has commenced for the development of a new approved centre on the campus of Sligo University Hospital. At the time of inspection, there were 17 residents in the 14-bedded female admission ward. Two interview rooms and a multi-purpose room had been used as bedrooms to accommodate the extra female residents. The seclusion room was also being used as a bedroom at the time of inspection. There were 12 residents in the 14-bedded male admission ward and 1 male in the 4-bedded high dependency ward. Although registered to provide mental health services for people with an intellectual disability, the approved centre was not suitable for this function.

Compliance with regulations decreased significantly from 79% in 2018 to 66 % in 2019. As compliance was 63% in 2017, there has been no overall improvement in three years. Five areas have been non-compliant for three consecutive years, all risk-rated as high. There were two conditions attached to the registration of the approved centre; related to premises and staffing. The centre was not in breach of either condition. Seven compliances with regulations were rated excellent.

At the time of the inspection the centre had seven high risk ratings in the areas of; premises staffing, general health, privacy, maintenance of records, risk management and physical restraint.

Regarding the premises, the approved centre was not kept in a good state of repair inside and outside. The premises were not maintained in good structural condition and did not provide suitable furnishings to support resident independence and comfort. There were no doors on residents' wardrobes. The centre did not have a dedicated therapy and examination room. The occupational therapy kitchen was dirty.

On the first day of the inspection, interview rooms where assessments were undertaken and where medical staff had resident meetings, were used as bedrooms. Appropriate signage and sensory aids were not provided to support resident orientation needs. The seclusion room was being used as a bedroom at the time of inspection.

Opportunities were not provided to residents for indoor and outdoor exercise and physical activity. The exercise bike and rowing machine on the male ward were broken at the time of the inspection. There was no exercise equipment on the female ward. There was no enclosed outdoor space. Accompanied walks were staff dependent, and rarely took place.

In relation to maintenance of records, there were errors in the medication prescription and administration records. Clinical files were poorly maintained, so much so that it posed a risk to patient safety. For example five out of seven clinical files inspected had loose pages; records were not in a logical order and not reflective of the residents' status at the time of inspection and the care and treatment being provided. Not all resident records were maintained using an identifier, which was unique to the resident. Not all residents' records included the date and time for each entry.

In terms of privacy residents did not have access to adequate personal space. The six-bedded dormitory on the male ward was cramped and there was not enough personal space to move about freely. The interview rooms on the female ward had observation panels without a screen or curtain. These two interview rooms had regularly been used as bedrooms. Female residents were inappropriately accompanied to the high dependency ward and seclusion room through the male admission ward. The light fittings in single bedrooms and in one dormitory were positioned on the outside of the door and there was no bedside lighting. The wardrobes did not have doors, which was not conducive to resident privacy and dignity.

The inspectors found the high risk noncompliance in risk management indicated that not all audits captured enough information to improve patient care and outcomes. There was no definitive audit schedule. Clinical audits had been primarily undertaken by nursing management, and there was limited evidence that other healthcare professionals had completed audits. In addition the monitoring, maintenance, and governance process regarding risk registers was unclear. Risks identified did not always identify risk owners, risk coordinators or risks ratings. The approved centre did not have an evacuation plan in place as per the services Incident Management Reporting Policy.

There was an induction programme for new staff; however, not all disciplines documented the induction process formally. Not all disciplines had formal structures and processes in place for measuring and encouraging staff's performance planning and personal development. The availability of clinical supervision varied across disciplines. Annual staff training plans were completed to identify required training; however, records indicated not all healthcare professionals had up-to-date mandatory training. Reportedly, the main barrier for healthcare professionals not achieving the required mandatory training was the prioritisation of clinical demand over training attendance.

Elm Mount Unit, St. Vincent's University Hospital Dublin 4 is situated in St. Vincent's University Hospital, Elm Park, Dublin 4. It is run in partnership between the HSE and the St. Vincent's Healthcare Group. Elm Mount Unit is a 39-bed unit divided into three areas: an acute admission unit; a sub-acute admission unit; and a specialist psychiatry of old age unit. Three beds are dedicated to residents with eating disorders.

Over the past three years there has been some improvement in compliance with regulations: 63% compliance in 2017, 59% in 2018 and 67% in 2019. The centre has been non-compliant with individual care planning and the code of practice on physical restraint for four consecutive years. Both of these non-compliances have been rated high risk on this inspection. Other high risk non compliances were privacy, premises, staffing, risk management and administration of medicines. Eight compliances with regulations were rated excellent. There were no conditions attached to the registration of this approved centre

In the administration of medicines there were a number of deficits in the medication prescription and administration record which could potentially lead to medication errors, including lack of documentation of allergies or sensitivities to any medications.

The closure of another service had resulted in an increased number of residents admitted to the approved centre with advanced stage dementia, and the limited space was identified by staff as a contributory factor in the increased number of reported violence, harassment, and aggression incidents.

On inspection, temperature was an issue in the approved centre due to a lack of ventilation. Poor ventilation remained an ongoing issue, particularly in the Electro Convulsive Therapy suite which had been identified as a risk. There were plans to install an air conditioning unit in this suite, but this had not been installed at the time of inspection. There was not enough space for residents to move about in the psychiatry of old age unit, or in the external courtyard. The doors of this unit were locked, impeding residents moving about in outdoor spaces and there was no dedicated facilities or therapy rooms available in the psychiatry of old age unit for individual or group therapies.

The shower room flooring surfaces were observed as being a hazard, as the flooring surface was uneven and this hazard was not minimised at the time of inspection. Despite a programme of general and decorative maintenance, the approved centre was not kept in a good state of repair; there were scuff marks on internal walls, the laminate covering at the bottom of the internal doors was chipped and the laminate flooring was disintegrating in some of the bedrooms, shower rooms and en suites. One external courtyard which was littered with discarded cigarette butts and used coffee cups. Additionally, one toilet room had toilet paper and posters on the floor.

Of the ten individual care plans inspected, three did not have appropriate goals, and one did not specify care and treatment interventions. Four of the care plans did not specify resources, as required and the occupational therapist was not present for the review of certain care plans.

In relation to staffing the skill mix of staffing was insufficient to meet residents' needs. A psychologist was assigned to the eating disorder unit but no psychologist was assigned to residents in the remaining 36 beds. Psychologists from the community mental health multi-disciplinary teams responded to referrals. There was a shortage of social workers. There was no recreational activities programme available within the approved centre. Recreational activities for residents was entirely dependent on availability of staff in the psychiatry of old age unit. These elderly residents did not always have access to nurse led activities, which was necessary for the resident group profile.

In privacy terms all bedrooms did not have a blind on the observation panel, and windows were without curtains. Not all windows had opaque glass, some bedrooms compromised residents' privacy by being overlooked by public areas. In addition the noticeboard contained residents' full names and this was visible from outside the nursing office through the glass.

The centre was also high risk rated for non-compliance as physical restraint was not carried out in accordance with the code of practice on physical restraint. In one case inspected, physical restraint was not reviewed by members of the multi-disciplinary team and documented in the clinical file no later than two working days after the episode. In three cases, it was not documented in the clinical file that the next of kin or representative was notified. In two episodes, it was not documented that the staff member responsible for leading in the physical restraint of a resident did not monitor the head and airway of the resident

St Gabriel's Ward, St Canice's Hospital, Kilkenny is a 20-bed facility, located within the grounds of St. Canice's Hospital in Kilkenny. Residents aged from late 50s to late 80s. There was a very significant improvement in the compliance with regulations. In 2017 and 2018, compliance was 59% and 58% respectively. In this inspection in 2019, compliance had risen to 88% and there were 13

compliances with regulations rated as excellent; there were two excellent ratings in 2018. There were no conditions attached to the registration

There was no regular social work or psychology input available to residents though access on a one-to-one specific basis could be arranged, if required. The approved centre was registered for rehabilitation services and the absence of dedicated social work and psychology input to this service meant that residents in this category did not have access to adequate and appropriate therapeutic services.

While the approved centre had a dedicated activities room the location of this facility was inconvenient for staff and residents and was not easily accessible. In the main, activities were provided in the main day room which also functioned as a recreation and dining area.

In a number of cases reviewed it was noted that there was a failure to follow-up in relation to required dental checks and, as a consequence, adequate arrangements to ensure that residents had access to dental services as required were not in place.

All three approved centres introduced quality initiatives which were identified on inspection Sligo / Leitrim Mental Health In-patient Unit recently started *This is my Care Plan Group* which informs residents of the care plan process and encourages them to take ownership of their care plan. Elm Mount Unit in St. Vincent's University Hospital had developed checklists to improve processes for physical restraint and searches while St Gabriel's Ward in Kilkenny had put a compliance officer in place since April 2019 which had assisted in the compliance improvements.

"Overcrowding in approved centres reduces the dignity and welfare of patients and is something that is unacceptable" said Chief Executive of the Mental Health Commission, John Farrelly. "Overcrowding, continued Mr Farrelly, "in the female unit in Sligo/Leitrim and an increase in the number of people admitted with advanced stage dementia to Elm Mount due to the closure of a service in the Dublin region, is poor strategic planning for the mental health service and people deserve better."

Ends

Inspection Reports

1. **Sligo/Leitrim Mental Health In-patient Unit**
   https://www.mhcirl.ie/File/2019IRs/SligoLeitrim_IR2019.pdf

The approved centre is a 32-bed acute adult mental health admission unit, located in Ballytivnan, on the outskirts of Sligo. The building dates from the 1930s and is unsuitable for providing a modern mental health service. Building has commenced for the development of a new approved centre on the campus of Sligo University Hospital. The approved centre is divided into a 14-bedded female, 14-bedded male and a 4-bedded high-dependency ward.

There were two conditions attached to the registration of this approved centre at the time of inspection.

Condition 1: To ensure adherence to Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update on the

programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.

Condition 2: To ensure adherence to Regulation 26(4): Staffing, the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date with mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.

Non-compliant areas on this inspection:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Regulation 6: Food Safety	✓		✓		X	Moderate
Regulation 9: Recreational Activities	✓		✓		X	Moderate
Regulation 19: General Health	✓		X	High	X	High
Regulation 21: Privacy	X	High	X	High	X	High
Regulation 22: Premises	X	High	X	High	X	High
Regulation 23: Ordering, Prescribing, Storing & Administration of Medicines	X	Moderate	✓		X	Moderate
Regulation 26: Staffing	X	High	X	High	X	High
Regulation 27: Maintenance of Records	X	Moderate	✓		X	High
Regulation 32: Risk Management Procedures	X	High	X	Critical	X	High
Rules Governing the Use of Seclusion	X	High	✓		X	Moderate
Code of Practice on the use of Physical Restraint in Approved Centres	X	Moderate	X	Moderate	X	High
Code of Practice on Admission, Transfer, and Discharge to and from an Approved Centre	X	Moderate	✓		X	Low

The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance. These are included in **Appendix 1** of the report.

Areas of compliance rated "excellent" on this inspection:

Regulation
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 10: Religion
Regulation 11: Visits
Regulation 16: Therapeutic Services and Programmes
Regulation 25: Use of Closed Circuit Television
Regulation 29: Operating Policies and Procedures
Regulation 30: Mental Health Tribunals

2. Elm Mount Unit, St. Vincent's University Hospital

https://www.mhcirl.ie/File/2019IRs/ElmMount_StVUH_IR_2019.pdf

Elm Mount Unit is an approved centre situated in St. Vincent's University Hospital, Elm Park, Dublin 4. It is run in partnership between the HSE and the St. Vincent's Healthcare Group. The approved centre provides mental health in-patient treatment and care to people living in the Community Healthcare Organisation (CHO) 6, namely the Dublin South East area. Elm Mount Unit is a 39-bed unit divided into three areas: Elm Mount Upper, an acute admission unit; Elm Mount Lower, a sub-acute admission unit; and a specialist Psychiatry of Old Age (POA) unit. Three beds in Elm Mount Lower, are dedicated to residents with eating disorders.

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

Non-compliant areas on this inspection:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Regulation 9: Recreational Activities	✓		✓		X	Moderate
Regulation 15: Individual Care Plan	X	High	X	Critical	X	High
Regulation 19: General Health	✓		✓		X	Moderate
Regulation 21: Privacy	✓		✓		X	High
Regulation 22: Premises	X	High	X	Moderate	X	High
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	X	Moderate	X	High	X	High
Regulation 26: Staffing	X	Moderate	X	High	X	High
Regulation 27: Maintenance of Records	X	Moderate	X	Moderate	X	Moderate
Regulation 31: Complaints Procedures	✓		✓		X	Moderate
Regulation 32: Risk Management Procedures	X	High	X	High	X	High
Code of Practice on the Use of Physical Restraint in Approved Centres	X	High	X	Critical	X	High

The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance. These are included in **Appendix 1** of the report.

Areas of compliance rated "excellent" on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 6: Food Safety
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 11: Visits
Regulation 12: Communication
Regulation 13: Searches

Regulation 30: Mental Health Tribunals

3. **St Gabriel's Ward, St.Canice's Hospital Kilkenny**
   https://www.mhcirl.ie/File/2019IRs/StGabrielsWard_IR_2019.pdf

https://www.mhcirl.ie/File/2019IRs/StGabrielsWard_IR_2019.pdfSt. Gabriel's Ward is a 20-bed facility, located within the grounds of St. Canice's Hospital in Kilkenny. The building is a single-storey facility dating from the 1980s. The approved centre accommodates residents under the care of the Psychiatry of Later Life (POLL) team, the Rehabilitation and Recovery team, and also general adult community teams. Residents aged from late 50s to late 80s.

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

Non-compliant areas on this inspection:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Regulation 15: Individual Care Plan	X	Low	X	High	X	Low
Regulation 16: Therapeutic Services and Programmes	✓		X	High	X	Moderate
Regulation 19: General Health	✓		X	Moderate	X	Moderate
Regulation 26: Staffing	X	High	X	High	X	Moderate

The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance. These are included in **Appendix 1** of the report.

Areas of compliance rated "excellent" on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 6: Food Safety
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 10: Religion
Regulation 12: Communication
Regulation 14: Care of the Dying
Regulation 21: Privacy
Regulation 29: Operating Policies and Procedures
Regulation 30: Mental Health Tribunals
Regulation 31: Complaints Procedures
Regulation 32: Risk Management Procedures

ENDS

For the Editor

About the Mental Health Commission:

The Mental Health Commission is an independent statutory body. The primary functions of the Mental Health Commission are to foster and promote high standards of care and good practice in the delivery of mental health services and to ensure that the interests of those involuntarily admitted are protected, pursuant to the Mental Health Act 2001.

Approved Centres:

A 'centre' is “a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder” (Mental Health Act 2001)

To operate an in-patient mental health service in Ireland, the service must be registered as an ‘approved centre’ with the Mental Health Commission. Each centre must re-register for approval every 3 years.

Upon registration, the service must comply with regulations made under the Mental Health Act 2001. Failure to comply with regulations may result in enforcement action including: corrective and preventative action plans, an immediate action notice, a regulatory compliance meeting, registration conditions, removal from the register (closure) and prosecution.

MHC inspection process:

There are 39 areas in the inspection process of approved mental health centres. Each approved centre is assessed against a suite of regulations, rules, and codes of practice.

Inspectors, over a three day period, use a combination of documentation review, observation and interview to assess compliance. The Inspection team

- speak with residents to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell them,
- review documents to see if appropriate records are kept, that they reflect practice, in line with the standards and are what people tell them.

Areas of inspection are deemed either compliant or non-compliant. Where areas are considered non-compliant, this is risk rated. Risk measurements are rated as low, moderate, high or critical.

Following the inspection, the Inspector prepares a report on the findings. A draft of the report is furnished to the registered proprietor of the approved centre, and includes provisional compliance ratings, risk ratings and quality assessments.

The registered proprietor is provided with an opportunity to review the draft and comment on any of the content or findings. The Inspector takes into account the comments by the registered proprietor and amends the report as appropriate.

Following this, the registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance addressing the specific non-compliances identified.

The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

Enforcement and monitoring processes
The Commission has a range of powers in relation to monitoring compliance of approved centres and where necessary, taking enforcement action.

The Commission will generally request a corrective and preventative action (CAPA) plan in the first instance and work with the service to address the concern. A CAPA plan must specifically address the non-compliance and put measures in place to prevent recurrence.

The Commission may issue an Immediate Action Notice where a concern needs to be addressed urgently.

The Commission can also direct services to attend a Regulatory Compliance Meeting at the Commission offices where they must provide evidence that they are implementing plans to address the concern. Where the Commission is not satisfied with plans provided, then the matter will be escalated.

The Commission may attach conditions to an approved centre's registration (similar to a penalty or endorsement on a driver licence). It is an offence to breach a condition of registration.
Where the Commission has ongoing and serious concerns about the care and treatment provided by an approved centre then it may remove the service from the register. This in effect means the closure of the approved centre.

Finally, there are a number of offences under the Act including offences relating to the failure or refusal to comply with the provision of the regulations. The Commission may decide to prosecute a service in relation to very serious and ongoing concerns.