# Report of the Inspector of Mental Health Services 2008

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| HSE AREA | HSE Dublin Mid-Leinster |
| CATCHMENT | National Service |
| MENTAL HEALTH SERVICE | National Service |
| APPROVED CENTRE | Central Mental Hospital |
| NUMBER OF UNITS OR WARDS | 7 |
| UNITS OR WARDS INSPECTED | Unit A, Unit B, Unit 4, Unit 2, Unit 3, Unit 7, Hostel |
| NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED | 84 |
| CONDITIONS ATTACHED TO REGISTRATION | No |
| TYPE OF INSPECTION | Announced |
| DATE OF INSPECTION | 30 October 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

The Central Mental Hospital provided forensic in-patient care on a national level. It provided high, medium and low secure accommodation and care. The service provided in-reach services for the prisons and court diversion services. Referrals to both in-reach services and court diversion services had been steadily increasing. There was also a day centre in Usher's Island as well as a community residence.

| WARD | NUMBER OF BEDS | NUMBER OF RESIDENTS | TEAM RESPONSIBLE |
|---|---|---|---|
| Unit A | 8 | 8 | Acute Cluster |
| Unit B | 12 | 12 | Acute Cluster |
| Unit 4 | 6 | 6 | Acute Cluster |
| Unit 2 | 16 | 16 | Medium Support Cluster |
| Unit 3 | 16 | 16 | Medium Support Cluster |
| Unit 7 | 15 | 15 | Medium Support Cluster |
| Hostel | 10 | 10 | Rehabilitation and Recovery Cluster |

The in-patient units were arranged in clusters of low secure, medium secure and admission units. There were two clinical teams for each cluster.

## RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

*1. The new in-patient building for the forensic services should proceed as quickly as possible in an alternative site that is not adjacent to a prison site.*

**Outcome:** The HSE had tendered for a project manager and a nurse planner for the new in-patient unit. It was expected that a design brief will be completed by 2010. Thornton Hall remains the identified site for the new forensic in-patient service.

*2. The review of the women's service that had commenced should continue and premises and facilities should be provided that are appropriate to the provision of a wide range of care and treatment options.*

**Outcome:** The service continues to review the needs of women within the forensic in-patient service. The range of therapeutic activities for women had increased. In the current building and financial restrictions, it has not been possible to provide different levels of secure care.

*3. Self-staffing ratios should continue to be enhanced on all wards.*

**Outcome:** Central staffing continues in the Central Mental Hospital. However there have been efforts to provide as much continuity as possible to different units.

*4. All written interventions should be dated, have a legible signature with the name and designation of the clinician clearly printed.*

**Outcome:** This had been achieved.

*5. Every effort should be made to end the routine practice of locking residents in remaining units at night.*

**Outcome:** This had not been achieved. The service stated that within the current complement of staff the levels required to achieve this are not available. Bedroom doors are left unlocked at night only in Unit 7 and in the Hostel Ward. All rooms have now been provided with a call bell.

*6. Communication between ward managers and the catering manager should be enhanced to ensure that the quality and variety of food is improved.*

**Outcome:** This had been achieved. Both staff and residents stated that the quality of food provided was good.

*7. The range of ward-based recreational and therapeutic activities available to all residents should be expanded.*

**Outcome:** There had been an increase in ward-based activities. Ward staff, social workers, occupational therapists and dedicated patient recreational staff provided ward-based programmes.

*8. All policies should be in line with the Regulations and Rules and a system put in place for regular review.*

**Outcome:** This had been achieved.

## MDT CARE PLANS 2008

All residents had a therapeutic care plan with inputs from all staff, including the unit staff and residents. All team meetings were held on the units. An excellent care pathway had been introduced for all new admissions and it was planned to roll this out to existing residents.

## GOOD PRACTICE DEVELOPMENTS 2008

- A patients' forum had been commenced. This extended to all units and was chaired by a service user.
- A gap analysis had commenced in the vocational therapies with the target of increasing the range and access of vocational services provided.
- Access to residents for their finances had become more structured.
- An integrated care pathway process had been introduced for all new admissions.
- There were now both male and female advocates.
- A broader range of therapeutic activities had been introduced, including expansion of therapeutic activities for women with increased access to Usher's Island.
- The number of staff on the prison in-reach team had increased.

## SERVICE USER INTERVIEWS

A number of residents spoke with the Inspectorate team. A small number had concerns about discharge. While all stated that the quality of the food had been improved, two residents complained that the quantities were too small and there was a lack of variety in the menu. The dinner food was inspected by the Inspectorate and found to be of good quality and adequate choice and quantity.

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

1. The process to provide new accommodation should continue as quickly as possible.

## 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 30 OCTOBER 2008

#### Article 5: Food and Nutrition

All units had a supply of fresh water. The quality of food had improved.

**Compliant:** Yes

#### Article 15: Individual Care Plan

All units had a care plan with inputs from all staff. An integrated care pathway had been introduced for all new residents.

**Compliant:** Yes

#### Article 16: Therapeutic Services and Programmes

The availability of therapeutic activities had increased for residents who were unable to leave the units and a detailed programme was available. The therapeutic activities available for women had also increased. Therapeutic activities were linked to residents' care plans.

**Compliant:** Yes

#### Article 17: Children's Education

There had been no child admissions to the service in the previous year.

**Compliant:** Not applicable

#### Article 18: Transfer of Residents

A policy on the transfer of residents to other centres and hospitals was in place. All relevant information, including a copy of the medication card index record, was sent with the resident on transfer.

**Compliant:** Yes

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

All residents had access to primary care and there was evidence of ongoing reviews of residents with medical problems. In some case files, there was no evidence that regular six-monthly reviews had taken place. No system was in place on the units to ensure that regular reviews took place. The Inspectorate was informed that these reviews were stored in a location away from the units. The service undertook to remedy this by initiating a system to record the practice that six monthly reviews were taking place and to keep documentation of all six monthly reviews in residents files.

**Compliant:** Yes

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

An excellent information book was available for all residents. This included a copy of their care plan and risk assessment, as well as housekeeping information, service information and advocacy information. The resident and key-worker compiled the information book. The residents were encouraged to keep this book in their rooms.

**Compliant:** Yes

## Article 21: Privacy

**Unit B:** Resident had their own rooms with toilet and wash-hand basin facilities in each room. There was an observation panel on the doors.

**Unit A:** Residents had their own rooms with toilet and wash-hand basin facilities in each room. There was an observation panel on the door for security purposes.

**Unit 2 and Unit 3:** Each resident had an individual bedroom. The observation panels had curtains for privacy.

**Compliant:** Yes

## Article 22: Premises

Some refurbishment had taken place and all units were clean. Unit A had been painted and there was a new seclusion suite. There was a new kitchen on Unit 3. Nevertheless the premises were not suitable for providing an in-patient forensic service. Some of the units required maintenance and painting. The bedrooms in the old buildings were small. In Unit B, the dayroom was far too small for 12 men and was environmentally very institutional. It was obvious that there were enormous difficulties in improving the structure and maintenance within the confines of the building.

**Breach:** Article 22 (1) and Article 22 (3).

**Compliant:** No

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

CCTV was used in Unit B and notices regarding its use were in clear view. However, records were kept of CCTV monitoring for 30 days on the unit. It was stated that this was for staff and resident security. The service stated that they wished to have discussions with the Mental Health Commission regarding the use of recording CCTV monitoring.

**Breach:** CCTV monitoring was recorded [Article 25 (1)(d)].

**Compliant:** No

## Article 26: Staffing

HSE policies on recruitment, selection and vetting of staff applied to the Central Mental Hospital. There was social work and occupational therapy input to the units. There was also psychology input, though two psychology vacancies had not yet been filled. There was evidence that staff had good access to training and educational programmes.

**Compliant:** Yes

## Article 27: Maintenance of Records

The HSE policy on retention of records applied and clinical files and care plans were in good order throughout the service.

**Compliant:** Yes

## Article 29: Operating policies and procedures

All policies were up to date and were provided on the day of inspection.

**Compliant:** Yes

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

### SECLUSION

Seclusion rates continued to fall in Units A, B and 4

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. All seclusion orders were completed. |
| **3** | **Patient 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. A policy was in place. Seclusion was audited regularly and there was a monthly multidisciplinary team meeting to review seclusion. |
| **10** | **Staff training** | Compliant |
| **11** | **CCTV** | Not applicable. CCTV was not used in the seclusion rooms. |
| **12** | **Child patients** | Not applicable |

**Compliant:** Yes

### ECT

ECT was not administered in the Central Mental Hospital.

**Compliant:** Not applicable

### MECHANICAL RESTRAINT

There was a draft working policy with the title *Use of Mechanical Means of Bodily Restraint (Handcuffs)*, due for review in May 2008. It stated that handcuffs were the only form of mechanical restraint to be used, and then only in the context of escorting and transporting residents outside the hospital.

All episodes of the use of handcuffs or prescription of handcuffs were accurately recorded in the register.

Mechanical restraint for enduring self-harm behaviour was not used in this approved centre.

**Compliant:** Yes

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

### 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** | Not applicable |

**Compliant:** Yes

### ADMISSION OF CHILDREN

No child had been admitted to the Central Mental Hospital in 2008.

**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** | Compliant |
| **4** | **Clinical governance** | Compliant |

**Compliant:** Yes

### ECT FOR VOLUNTARY PATIENTS

ECT was not administered in the Central Mental Hospital.

**Compliant:** Not applicable

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

The approved centre was compliant.

**Compliant:** Yes