Report of the Inspector of Mental Health Services 2013

EXECUTIVE CATCHMENT AREA/INTEGRATED SERVICE AREA	Galway, Roscommon
HSE AREA	West
MENTAL HEALTH SERVICE	Galway West
APPROVED CENTRE	Department of Psychiatry (DOP), Galway University Hospital
NUMBER OF WARDS	1
NAMES OF UNITS OR WARDS INSPECTED	DOP
TOTAL NUMBER OF BEDS	35
CONDITIONS ATTACHED TO REGISTRATION	Yes
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	26 February 2013

Summary

- The DOP did not provide an individual care plan for each resident. This breached the condition attached by the Mental Health Commission to the Registration of the approved centre.
- The ante-room which comprised part of the seclusion room suite continued to be used intermittently as a bedroom. The seclusion suite must only be used for seclusion purposes and in accordance with the Rules. Staff must meet their professional and legal obligations in this respect.
- The purpose built high dependency unit located on the lower ground floor, which contained individual bedrooms and seclusion facilities, had never been opened despite the high costs of both the build and commissioning. The unit was now used to provide office accommodation to clinical staff.
- The standard of records maintenance was inadequate for the third year in a row.
- Plans to build a new DOP on the hospital campus were at an advanced stage.

OVERVIEW

In 2013, the Inspectorate inspected this Approved Centre against all of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

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 2012. In addition to the core inspection process information was also gathered from advocacy reports, service user interviews, staff interviews and photographic evidence collected on the day of the inspection.

DESCRIPTION

The Department of Psychiatry (DOP), University Hospital Galway, was located at the rear of the main hospital building. Residents' accommodation was single story and comprised mainly four and six bedded dormitories and some single rooms and was divided into a male and a female wing. Some of the sleeping areas were open-plan incorporating the main unit corridor with bedside curtains providing what privacy there was. There was an activities area adjacent to the unit and this provided an excellent environment for residents to both leave the unit and to engage in a range of activities during the day. On the day of inspection there were 34 persons resident, 13 of whom were detained and six patients were on approved leave. There were no child residents and no resident with an intellectual disability and a mental illness.

The Mental Health Commission had attached a condition, with effect from the 6th November 2012, to the Registration of the Department of Psychiatry, University Hospital Galway: "The Mental Health Commission requires full compliance with Article 15 (Individual Care Plan) of S.I. No 551 of 2006; Mental Health Act 2001 (Approved Centres) Regulations 2006.

The reasons for the decision to attach this condition are as follows: Page 15 of the Report of the Inspector of Mental Health Services 2012 for the Department of Psychiatry, University Hospital Galway states "Fourteen individual clinical files were inspected and of these only two had individual care plans which met the requirements of the Regulations. The approved centre failed to meet the standard of Article 15 for the fourth year in succession". Page 52 of the Report of the Inspector of Mental Health Services 2012 for the Department of Psychiatry, University Hospital Galway states "The absence of individual care plans for many residents for the fourth year in a row was very disappointing". "

SUMMARY OF COMPLIANCE WITH MENTAL HEALTH ACT 2001 (APPROVED CENTRES) REGULATIONS 2006

COMPLIANCE RATING	2011	2012	2013	ARTICLE NUMBERS 2013
Fully Compliant	24	22	23	-
Substantial Compliance	2	4	2	29, 32
Minimal Compliance	1	1	1	27
Not Compliant	3	3	3	15, 16, 22
Not Applicable	1	1	2	17, 25

PART ONE: QUALITY OF CARE AND TREATMENT SECTION 51 (1)(b)(i) MENTAL HEALTH ACT 2001

DETAILS OF WARDS IN THE APPROVED CENTRE

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Department of Psychiatry	35	34	General Adult Psychiatry of Later Life

QUALITY INITIATIVES 2012/2013

1. A consultant psychiatrist had been appointed to the intellectual disability services. It had been agreed that the consultant would provide one day per week to the Health Service Executive mental health services in West Galway.
2. An audit on hand hygiene had been completed in December 2012.
3. An audit of falls in the DOP had been completed.
4. A consumer panel for the West Galway mental health services was in the process of being established.
5. Two nurses were undertaking Master degrees in cognitive behaviour therapy.
6. An ECT training course for nursing staff had been developed.

PROGRESS ON RECOMMENDATIONS IN THE 2012 APPROVED CENTRE REPORT

1. All residents must have an individual care plan.

Outcome: This was not delivered.

2. Individual clinical records must be maintained in an acceptable manner.

Outcome: There were two types of individual clinical files being used within the DOP. The older type, continued to have envelope sections which were integral to the file cover, which contained loose sheets. Nursing notes were kept in a separate file. The integrity and maintenance of individual clinical files was not satisfactory.

3. Staff should be trained in the care and management of individuals with an intellectual disability and a mental illness.

Outcome: This had not been done.

4. The seclusion room must not be used as a bedroom. Where an individual is being contained in the seclusion room and is not free to leave this room, the human rights safeguards applied in relation to seclusion should be implemented.

Outcome: The ante-room in the seclusion room suite continued to be used as a bedroom.

5. There should be an adequate number of health and social care professionals on the multidisciplinary teams to meet the identified needs of residents.

Outcome: Rated fully compliant at Article 26.

PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE, AND SECTION 60, MHA 2001

2.2 EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)

Article 4: Identification of Residents

The registered proprietor shall make arrangements to ensure that each resident is readily identifiable by staff when receiving medication, health care or other services.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The approved centre did not use photographic or wristband identification. Staff reported that residents were known to staff and that medication was always administered by two nursing staff.

Article 5: Food and Nutrition

(1) The registered proprietor shall ensure that residents have access to a safe supply of fresh drinking water.

(2) The registered proprietor shall ensure that residents are provided with food and drink in quantities adequate for their needs, which is properly prepared, wholesome and nutritious, involves an element of choice and takes account of any special dietary requirements and is consistent with each resident's individual care plan.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X		X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*		X	
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The dining room menu was posted and offered a choice of meals. Residents ordered their choice of meal at the servery. There was fresh drinking water available throughout the DOP.

Article 6 (1-2): Food Safety

(1) The registered proprietor shall ensure:

(a) the provision of suitable and sufficient catering equipment, crockery and cutlery

(b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and

(c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.

(2) This regulation is without prejudice to:

(a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;

(b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and

(c) the Food Safety Authority of Ireland Act 1998.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The most recent Environmental Health Officer's report was available for inspection.

Article 7: Clothing

The registered proprietor shall ensure that:

(1) when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;

(2) night clothes are not worn by residents during the day, unless specified in a resident's individual care plan.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Residents wore day clothes unless otherwise specified in the individual clinical file. There was a small supply of night attire if required and staff reported that the social work department sourced a small fund in the event of a resident not having sufficient personal supply of clothing whilst in hospital. Laundry facilities were available for residents.

Article 8: Residents' Personal Property and Possessions

(1) For the purpose of this regulation "personal property and possessions" means the belongings and personal effects that a resident brings into an approved centre; items purchased by or on behalf of a resident during his or her stay in an approved centre; and items and monies received by the resident during his or her stay in an approved centre.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures relating to residents' personal property and possessions.

(3) The registered proprietor shall ensure that a record is maintained of each resident's personal property and possessions and is available to the resident in accordance with the approved centre's written policy.

(4) The registered proprietor shall ensure that records relating to a resident's personal property and possessions are kept separately from the resident's individual care plan.

(5) The registered proprietor shall ensure that each resident retains control of his or her personal property and possessions except under circumstances where this poses a danger to the resident or others as indicated by the resident's individual care plan.

(6) The registered proprietor shall ensure that provision is made for the safe-keeping of all personal property and possessions.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a policy on residents' personal property and possessions. A property checklist was completed at the time of admission and was countersigned. Each resident had a locker and a bedside locker. There was provision for safe storage if required.

Article 9: Recreational Activities

The registered proprietor shall ensure that an approved centre, insofar as is practicable, provides access for residents to appropriate recreational activities.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was good provision for recreational activities within the DOP. There were television, DVD player, music centre, table games, books and art resources available. A benefactor had donated monies which enabled the purchase of a new pool table. Books were regularly donated also. There was an excellent mini-gym within the DOP and a number of nursing staff were qualified to supervise physical recreation programmes.

The provision of a daily newspaper within the ward had been discontinued owing to budgetary considerations. There was a shop within the University Hospital Galway where daily papers were on sale and a shop trolley was available within the DOP each day.

Article 10: Religion

The registered proprietor shall ensure that residents are facilitated, insofar as is reasonably practicable, in the practice of their religion.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Residents of all faiths were facilitated in the practice of their religion insofar as was practicable. The hospital Chaplain visited the ward each Sunday and there was a ready-to-hand list of contacts for a range of religious faiths within Galway city.

Article 11 (1-6): Visits

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.

(2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.

(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.

(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident's individual care plan.

(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.

(6) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a policy on visits. Visiting times were aligned with those of the University Hospital Galway, however, flexibility applied especially in relation to visitors who might have travelled from outlying areas. There was no visitors room but there was sufficient space within the DOP to facilitate visits.

Article 12 (1-4): Communication

(1) Subject to subsections (2) and (3), the registered proprietor and the clinical director shall ensure that the resident is free to communicate at all times, having due regard to his or her wellbeing, safety and health.

(2) The clinical director, or a senior member of staff designated by the clinical director, may only examine incoming and outgoing communication if there is reasonable cause to believe that the communication may result in harm to the resident or to others.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on communication.

(4) For the purposes of this regulation "communication" means the use of mail, fax, email, internet, telephone or any device for the purposes of sending or receiving messages or goods.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a policy on communication. Residents were free to send and receive mail unopened. There was a public telephone available for residents. Residents could retain their personal mobile telephones unless clinically indicated otherwise.

Article 13: Searches

(1) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated.

(2) The registered proprietor shall ensure that searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for carrying out searches with the consent of a resident and carrying out searches in the absence of consent.

(4) Without prejudice to subsection (3) the registered proprietor shall ensure that the consent of the resident is always sought.

(5) The registered proprietor shall ensure that residents and staff are aware of the policy and procedures on searching.

(6) The registered proprietor shall ensure that there is be a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

(7) The registered proprietor shall ensure that all searches are undertaken with due regard to the resident's dignity, privacy and gender.

(8) The registered proprietor shall ensure that the resident being searched is informed of what is happening and why.

(9) The registered proprietor shall ensure that a written record of every search is made, which includes the reason for the search.

(10) The registered proprietor shall ensure that the approved centre has written operational policies and procedures in relation to the finding of illicit substances.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a policy in place in relation to the carrying out of searches with and without consent and on the finding of illicit substances. Staff reported that no searches had been carried out in 2013 up to the time of inspection.

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

(1) The registered proprietor shall ensure that the approved centre has written operational policies and protocols for care of residents who are dying.

(2) The registered proprietor shall ensure that when a resident is dying:

(a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;

(b) in so far as practicable, his or her religious and cultural practices are respected;

(c) the resident's death is handled with dignity and propriety, and;

(d) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:

(a) in so far as practicable, his or her religious and cultural practices are respected;

(b) the resident's death is handled with dignity and propriety, and;

(c) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(4) The registered proprietor shall ensure that the Mental Health Commission is notified in writing of the death of any resident of the approved centre, as soon as is practicable and in any event, no later than within 48 hours of the death occurring.

(5) This Regulation is without prejudice to the provisions of the Coroners Act 1962 and the Coroners (Amendment) Act 2005.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a policy on the care of residents who are dying. A single room was available.

Article 15: Individual Care Plan

The registered proprietor shall ensure that each resident has an individual care plan.

[Definition of an individual care plan:"... a documented set of goals developed, regularly reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation".]

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*			
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*	X	X	X

Justification for this rating:

This Article requires that each resident has an individual care plan (ICP) as defined in the Regulations. Four of the individual clinical files inspected did not have ICPs as required.

The quality of ICPs in general was variable and in most instances there was no evidence of resident input. Inspectors examined both the ICP template documentation and the clinical progress note to evaluate the ICP process. The record of personnel in attendance at the weekly multidisciplinary team (MDT) review meeting was faithfully recorded. There were also weekly evaluation notes entitled "evaluation of multidisciplinary care plan" which were also completed, however, these were typically framed as progress notes. In the absence of an ICP, which included a clear statement of identified needs, clear goals, the specified interventions, the person and time frame allotted for each intervention, and current outcome, the progress notes did not provide a clear overview of the care pathway.

Service user voice was not well captured and it was not clear how this was factored into the MDT care planning process: staff reported that residents did not attend the MDT review meeting; the section on the ICP template relating to the "patient" was generally blank; whilst it was good practice to

record direct quotes of a resident in the clinical progress notes, these did not convey the extent to which a resident was involved in their own care planning process. One clinical file recorded “previous failure of care plans” but this was not elucidated from the perspective of the resident, the family or the MDT. It was disappointing to generally see only scant information recorded in relation to social, educational and vocational history and strengths. The individual clinical files inspected relating to the Carraroe and Renmore sector teams had ICPs in place. For the fifth year in succession the DOP failed to provide an ICP for each resident.

Breach: 15

Article 16: Therapeutic Services and Programmes

(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.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*			
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*	X	X	X

Justification for this rating:

An ICP was not in place for each resident and therefore therapeutic services and programmes were not delivered in accordance with the individual care plan.

The adjacent Activation Unit provided an opportunity for residents to leave the ward areas. Nursing staff had created an environment that fostered relaxation, engagement in activities and social interaction. The activities nurse provided activities including, relaxation class, beauty therapy, art, aromatherapy, a pre-discharge group and a Wellness and Recovery Action Plan (WRAP) group. Resident attendance was noted in the separate nursing notes. Nursing staff were enthusiastic and sought to facilitate resident participation.

In the absence of an ICP it was not possible to evaluate to what extent a resident might progress their own health status and psychosocial recovery through engagement in the therapeutic services and programmes provide. Or to evaluate what gain an individual might derive from the activities programme beyond the generic benefits of activation, socialisation and diversion.

The individual clinical files evidenced therapeutic input from clinical psychology and social work. There was no recorded occupational therapy input in the files inspected. Where the MDT input was articulated in terms of needs, goals and outcome, it was easy to track a resident's progress and discharge planning. Otherwise the individual clinical files did not provide a clear picture of the context

of care, the trajectory of progress and the care pathway.

Breach: 16 (1), (2)

Article 17: Children's Education

The registered proprietor shall ensure that each resident who is a child is provided with appropriate educational services in accordance with his or her needs and age as indicated by his or her individual care plan.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	**X**		**NOT APPLICABLE**
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*		**X**	
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

No child had been admitted to the approved centre in 2013 up to the time of inspection.

Article 18: Transfer of Residents

(1) When a resident is transferred from an approved centre for treatment to another approved centre, hospital or other place, the registered proprietor of the approved centre from which the resident is being transferred shall ensure that all relevant information about the resident is provided to the receiving approved centre, hospital or other place.

(2) The registered proprietor shall ensure that the approved centre has a written policy and procedures on the transfer of residents.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The approved centre had a policy and procedures for the transfer of a resident to another treatment facility. A nursing transfer form was used and all relevant clinical information accompanied the resident on transfer.

Article 19 (1-2): General Health

(1) The registered proprietor shall ensure that:

(a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;

(b) each resident's general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;

(c) each resident has access to national screening programmes where available and applicable to the resident.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for responding to medical emergencies.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*		X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*	X		
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Two residents had been admitted for longer than six months and both these residents had a physical examination carried out. There was a policy relating to responding to medical emergencies.

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

(1) Without prejudice to any provisions in the Act the registered proprietor shall ensure that the following information is provided to each resident in an understandable form and language:

(a) details of the resident's multi-disciplinary team;

(b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;

(c) verbal and written information on the resident's diagnosis and suitable written information relevant to the resident's diagnosis unless in the resident's psychiatrist's view the provision of such information might be prejudicial to the resident's physical or mental health, well-being or emotional condition;

(d) details of relevant advocacy and voluntary agencies;

(e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

(2) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for the provision of information to residents.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was an up-to-date policy relating to provision of information to residents. There was an information leaflet for residents which addressed the items identified in this Article. Information was provided on diagnoses and treatments. The pharmacist provided information to residents also.

Article 21: Privacy

The registered proprietor shall ensure that the resident's privacy and dignity is appropriately respected at all times.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The layout of sleeping accommodation whereby the dormitory space was continuous with the corridor. Nursing staff had assigned sleeping accommodation with a view to maximising privacy. All beds had surround curtains. Lavatory and washing accommodation was lockable and privacy and dignity were respected throughout the approved centre.

Article 22: Premises

(1) The registered proprietor shall ensure that:

(a) premises are clean and maintained in good structural and decorative condition;

(b) premises are adequately lit, heated and ventilated;

(c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

(2) The registered proprietor shall ensure that an approved centre has adequate and suitable furnishings having regard to the number and mix of residents in the approved centre.

(3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff and visitors.

(4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose in so far as it practicable and in accordance with best contemporary practice.

(5) Any approved centre in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall ensure that the buildings are, as far as practicable, accessible to persons with disabilities.

(6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and 2001, Part M of the Building Regulations 1997, the Disability Act 2005 and the Planning and Development Act 2000.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*			
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*	X	X	X

Justification for this rating:

The unit was clean and tidy. Maintenance and upkeep had been kept to a minimum and several areas were shabby. A new unit was due to be built.

Breach: 22 1 (a), (c)

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

(1) The registered proprietor shall ensure that an approved centre has appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.

(2) This Regulation is without prejudice to the Irish Medicines Board Act 1995 (as amended), the Misuse of Drugs Acts 1977, 1984 and 1993, the Misuse of Drugs Regulations 1998 (S.I. No. 338 of 1998) and 1993 (S.I. No. 338 of 1993 and S.I. No. 342 of 1993) and S.I. No. 540 of 2003, Medicinal Products (Prescription and control of Supply) Regulations 2003 (as amended).

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a policy relating to the ordering, storing, prescribing and administration of medicines. The pharmacist provided regular input to the multidisciplinary teams and was available to provide information to residents.

Article 24 (1-2): Health and Safety

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the health and safety of residents, staff and visitors.

(2) This regulation is without prejudice to the provisions of Health and Safety Act 1989, the Health and Safety at Work Act 2005 and any regulations made thereunder.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The approved centre had a Health and Safety statement and related policies.

Article 25: Use of Closed Circuit Television (CCTV)

(1) The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:

(a) it shall be used solely for the purposes of observing a resident by a health

professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

(b) it shall be clearly labelled and be evident;

(c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;

(d) it shall be incapable of recording or storing a resident's image on a tape, disc,

hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;

(e) it must not be used if a resident starts to act in a way which compromises his or

her dignity.

(2) The registered proprietor shall ensure that the existence and usage of closed circuit television or other monitoring device is disclosed to the resident and/or his or her representative.

(3) The registered proprietor shall ensure that existence and usage of closed circuit television or other monitoring device is disclosed to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the approved centre or at anytime on request.

CCTV was not used in the approved centre and this Article was not applicable.

Article 26: Staffing

(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.

WARD OR UNIT	STAFF TYPE	DAY	NIGHT
Department of Psychiatry	CNM3	0	1
	CNM2	2	0
	CNM1	0	0
	RPN	6	4

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Non Consultant Hospital Doctor (NCHD),Director of Nursing, (DON), Assistant Director of Nursing (ADON).

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X		X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*		X	
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The Health Service Executive (HSE) policies and procedures in relation to the recruitment, vetting and appointment of staff applied. There was a very detailed record of nurse training.

Additional health and social care professionals had been appointed and at the time of inspection it was reported that there were: 5.6 social workers; five clinical psychologists and 3.8 occupational therapy (OT) wholetime-equivalent posts in place. One OT post was vacant owing to leave. The individual clinical files inspected contained clinical records for clinical psychology and social work interventions.

Article 27: Maintenance of Records

(1) The registered proprietor shall ensure that records and reports shall be maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. All records shall be kept up-to-date and in good order in a safe and secure place.

(2) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the creation of, access to, retention of and destruction of records.

(3) The registered proprietor shall ensure that all documentation of inspections relating to food safety, health and safety and fire inspections is maintained in the approved centre.

(4) This Regulation is without prejudice to the provisions of the Data Protection Acts 1988 and 2003 and the Freedom of Information Acts 1997 and 2003.

The Inspectorate did not inspect and has no expertise in assessing fire risk

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*			
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*	X	X	X
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The policy in relation to records was out of date.

A number of individual clinical files inspected contained poorly maintained records. In one instance entries in the Register for Seclusion in relation to one episode of seclusion were incorrectly dated by three separate members of staff. Progress notes recorded by one member of nursing staff in relation to one resident were scribbled out in several places and also written in the areas of the clinical file designed to record date and signature.

One clinical file inspected contained a bulky pocket on the cover of the file which contained clinical records in loose sheets, in no particular chronological or subject order, and data dating back to 1998 and 2000.

Signatures in the clinical records were often illegible and did not necessarily indicate the professional role of the signatory. Medical Council Numbers (MCNs) were not routinely used by all medical staff. This was the third year for the approved centre to fail to meet the standard required for the maintenance of clinical records. In 2012 staff reported that a new clinical file was being introduced and it was anticipated that this would address record management issues. Staff reiterated this in 2013. The issue of record management is a governance and professional responsibility.

Records in relation to fire safety and food hygiene were available on the day of inspection.

Breach: 27(1),(2)

Article 28: Register of Residents

(1) The registered proprietor shall ensure that an up-to-date register shall be established and maintained in relation to every resident in an approved centre in a format determined by the Commission and shall make available such information to the Commission as and when requested by the Commission.

(2) The registered proprietor shall ensure that the register includes the information specified in Schedule 1 to these Regulations.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X		X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*		X	
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The Register of Residents document template did not make provision for the recording of PPS numbers, however, this information was requested from residents and if provided was recorded within the Register.

Article 29: Operating policies and procedures

The registered proprietor shall ensure that all written operational policies and procedures of an approved centre are reviewed on the recommendation of the Inspector or the Commission and at least every 3 years having due regard to any recommendations made by the Inspector or the Commission.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The majority of policies were in place and reviewed on a regular basis. Policies were available to staff on computer and were readily accessible. The policy on Maintenance of Records was out of date. The approved centre advised that, the Records policy has been updated since the date of the inspection.

Breach: 29

Article 30: Mental Health Tribunals

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.

(2) In circumstances where a patient's condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The approved centre facilitated Mental Health Tribunals and assisted patients to attend.

Article 31: Complaint Procedures

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre.

(2) The registered proprietor shall ensure that each resident is made aware of the complaints procedure as soon as is practicable after admission.

(3) The registered proprietor shall ensure that the complaints procedure is displayed in a prominent position in the approved centre.

(4) The registered proprietor shall ensure that a nominated person is available in an approved centre to deal with all complaints.

(5) The registered proprietor shall ensure that all complaints are investigated promptly.

(6) The registered proprietor shall ensure that the nominated person maintains a record of all complaints relating to the approved centre.

(7) The registered proprietor shall ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.

(8) The registered proprietor shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

(9) This Regulation is without prejudice to Part 9 of the Health Act 2004 and any regulations made thereunder.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*		X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*	X		
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was an up-to-date policy relating to the complaints procedures. Information about how to make a complaint was made available to residents and families. There was a nominated person to deal with complaints within the approved centre. A record of complaints was not kept at ward level but was maintained within the approved centre. This log was inspected and it was well maintained, was reviewed by senior management regularly and the response to complaints was clearly recorded.

Article 32: Risk Management Procedures

(1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:

(a) The identification and assessment of risks throughout the approved centre;

(b) The precautions in place to control the risks identified;

(c) The precautions in place to control the following specified risks:

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;

(e) Arrangements for responding to emergencies;

(f) Arrangements for the protection of children and vulnerable adults from abuse.

(3) The registered proprietor shall ensure that an approved centre shall maintain a record of all incidents and notify the Mental Health Commission of incidents occurring in the approved centre with due regard to any relevant codes of practice issued by the Mental Health Commission from time to time which have been notified to the approved centre.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a policy relating to risk management. The practice of recording risk assessment and management had not been maintained to the same high standard achieved in 2012. Individual clinical files all contained a risk assessment completed at the time of admission. The individual clinical files inspected contained a brief clinical risk screening tool that was different from the one specified in the policy.

One individual clinical file inspected related to a resident admitted on three occasions over as many months, who had a past history of violence towards others, and current expressed intent to harm others in the context of paranoid psychosis. The completed risk assessment contained an illegible signature, no indication of the professional status of the assessor, identified several significant risk factors but with no elucidation, and did not contain any recommendations for risk management. This risk assessment did not indicate review by the multidisciplinary team, or indicate the source of information and did not record a structured clinical judgement.

One individual clinical file inspected related to a resident admitted following a serious violent assault on another person. There were two completed risk assessments in the file, one was undated. The items ticked as risk items on the screening tool did not match well with the clinical notes. The risk assessment did not identify the source of information, did not identify a risk management plan and did not indicate if the risk assessment was reviewed by the multidisciplinary team.

One individual clinical file inspected contained a risk assessment which rated the resident as requiring “high risk” observation but didn’t state what that risk was and did not have a risk management plan. The signature was illegible and did not identify the professional status of the assessor.

Breach: 32 (1)

Article 33: Insurance

The registered proprietor of an approved centre shall ensure that the unit is adequately insured against accidents or injury to residents.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The approved centre was insured under the State Indemnity Scheme.

Article 34: Certificate of Registration

The registered proprietor shall ensure that the approved centre's current certificate of registration issued pursuant to Section 64(3)(c) of the Act is displayed in a prominent position in the approved centre.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The Certificate of Registration was displayed within the approved centre.

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

SECLUSION

Use: Seclusion was used in the approved centre.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
1	General principles	X			
3	Orders		X		
4	Patient dignity and safety	X			
5	Monitoring of the patient	X			
6	Renewal of seclusion orders	X			
7	Ending seclusion	X			
8	Facilities		X		
9	Recording			X	
10	Clinical governance	X			
11	Staff training	X			
12	CCTV	NOT APPLICABLE			
13	Child patients	NOT APPLICABLE			

Justification for this rating:

The clinical files of two residents who had three episodes of seclusion and the Seclusion Register were inspected. In relation to one resident, there was evidence in the clinical file that the episode was documented and that the episode had been discussed with the resident afterwards. A copy of the order was placed in the resident's clinical file.

In relation to the second resident, the date of seclusion was incorrectly dated in the Register in three separate places. Accordingly, the episode was documented in the clinical file on another date. The order form was still in the Register as were nine other copies of episodes of seclusion relating to other residents. There was no evidence in the Register to indicate whether the resident's next of kin had been informed of the episode as this section of the order form was left blank.

The seclusion room was designed such that the area was divided in two sections, one of which held a bed and a second section partitioned from this area which could be locked. Inspectors were of the view that the use of the section with the bed constituted the use of the seclusion facility as a bedroom. A bed had been placed in this room on the day of inspection. This was not good practice and blurred the boundaries in relation to seclusion. This blurring was evident on a previous occasion in 2012 where inspectors observed a resident being prevented from leaving this room by a nurse physically occluding a resident's exit. Inspectors made a recommendation in 2012 that the seclusion room must not be used as a bedroom and where a resident was not free to leave a room that the human rights safeguards applied in relation to seclusion should be implemented. Inspectors sought to clarify the approved centre's practice in this regard in 2013, however, discussion with staff did not provide an adequate explanation for such continued use of this room.

There was an up-to-date policy relating to the Use of Seclusion.

Breach: 3.7, 8.4, 9.1, 9.2, 9.3

Electroconvulsive Therapy (ECT) (DETAINED PATIENTS)

Use: No detained patient was receiving ECT at the time of inspection.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
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	X			
10	Materials and equipment	X			
11	Staffing	X			
12	Documentation	NOT APPLICABLE			
13	ECT during pregnancy	NOT APPLICABLE			

Justification for this rating:

There was an excellent ECT suite comprising a waiting room, treatment room and a recovery room. There was a designated ECT nurse and consultant psychiatrist. The approved centre had just received ECTAS (ECT Accreditation Standards) approval for its ECT facilities and practices.

MECHANICAL RESTRAINT

Use: Mechanical restraint was not used in the approved centre.

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

PHYSICAL RESTRAINT

Use: Physical restraint was used in the approved centre.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
1	General principles	X			
5	Orders		X		
6	Resident dignity and safety	X			
7	Ending physical restraint	X			
8	Recording use of physical restraint		X		
9	Clinical governance	X			
10	Staff training	X			
11	Child residents	NOT APPLICABLE			

Justification for this rating:

There was an up-to-date policy relating to the use of physical restraint. Staff training was up to date. Two Clinical Practice Form Books for physical restraint were examined. The signature of the consultant psychiatrist at section 17 was blank in three instances. The copy of the order form was not placed in the resident's clinical file in four instances. Other aspects of recording were satisfactory.

Breach: 5.7(c), 8.3

ADMISSION OF CHILDREN

Description: No child had been admitted to the approved centre in 2013 up to the time of inspection.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
2	Admission	NOT APPLICABLE			
3	Treatment	NOT APPLICABLE			
4	Leave provisions	NOT APPLICABLE			

Justification for this rating:

There was a policy relating to family liaison and children's education. The approved centre's policy was that children would only be admitted to the DOP as a last resort and if no bed was available in a CAMHS approved centre. No child had been admitted in 2013 up to the date of inspection.

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

Description: There had been no deaths in the approved centre in 2013 up to the time of inspection.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
2	**Notification of deaths**	**NOT APPLICABLE**			
3	**Incident reporting**	**X**			
4	**Clinical governance (identified risk manager)**	**X**			

Justification for this rating:

The approved centre reported incidents to the Mental Health Commission. There was an excellent incident report record and this was reviewed regularly by the Clinical Director and the Clinical Governance committee. There was an identified risk manager with responsibility for mental health services.

Electroconvulsive Therapy (ECT) FOR VOLUNTARY PATIENTS

Use: ECT was used in the approved centre, and one resident had a programme of ECT in 2013 to the date of the inspection. No current resident was receiving ECT.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
4	Consent	NOT APPLICABLE			
5	Information	X			
6	Prescription of ECT	NOT APPLICABLE			
7	Assessment of voluntary patient	NOT APPLICABLE			
8	Anaesthesia	NOT APPLICABLE			
9	Administration of ECT	NOT APPLICABLE			
10	ECT Suite	X			
11	Materials and equipment	X			
12	Staffing	X			
13	Documentation		X		
14	ECT during pregnancy	NOT APPLICABLE			

Justification for this rating:

There was an excellent ECT suite and a designated ECT nurse and consultant psychiatrist. The service had a very good information booklet for residents undergoing ECT. The ECT register was inspected. Two forms were retained in the Register and had not been placed in the relevant residents' clinical files.

Breach: 13.1

ADMISSION, TRANSFER AND DISCHARGE

Part 2 Enabling Good Practice through Effective Governance

The following aspects were considered: 4. policies and protocols, 5. privacy confidentiality and consent, 6. staff roles and responsibility, 7. risk management, 8. information transfer, 9. staff information and training.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
	X		

Justification for this rating:

The approved centre had admission, transfer and discharge policies. A key worker system operated and staff roles were clearly stated. The approved centre was not fully compliant with Article 32 on Risk Management because it did not fully implement its own policy.

Breach: 7.1

Part 3 Admission Process

The following aspects were considered: 10. pre-admission process, 11. unplanned referral to an Approved Centre, 12. admission criteria, 13. decision to admit, 14. decision not to admit, 15. assessment following admission, 16. rights and information,17. individual care and treatment plan, 18. resident and family/carer/advocate involvement, 19. multidisciplinary team involvement, 20. key-worker, 21. collaboration with primary health care community mental health services, relevant outside agencies and information transfer, 22. record-keeping and documentation, 23. day of admission, 24. specific groups.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
		X	

Justification for this rating:

The clinical file of a resident recently admitted was inspected. Mental state and physical examinations had been carried out by the admitting doctor. A risk assessment had also been carried out, but this was not dated. The service operated a key worker system. Every resident did not have an individual care plan and nursing notes were kept in a folder separate from other disciplines. The approved centre was fully compliant with Article 7, relating to Clothing, Article 8 relating to Resident's Personal Property and Possessions and Article 20 relating to Provision of Information to Residents. It was not fully compliant with Article 15 relating to Individual Care Plans and Article 27 relating to Maintenance of Records.

Breach: 17.1, 22.1, 22.7

Part 4 Transfer Process

The following aspects were considered: 25. Transfer criteria, 26. decision to transfer, 27. assessment before transfer, 28. resident involvement, 29. multidisciplinary team involvement, 30. communication between Approved Centre and receiving facility and information transfer, 31. record-keeping and documentation, 32. day of transfer.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
NOT APPLICABLE			

Justification for this rating:

None of the persons resident on the day of inspection had been transferred to another facility for care or treatment.

Part 5 Discharge Process

The following aspects were considered: 33. Decision to discharge, 34. discharge planning, 35. pre-discharge assessment, 36. multi-disciplinary team involvement, 37. key-worker, 38. collaboration with primary health care, community mental health services, relevant outside agencies and information transfer, 39. resident and family/carer/advocate involvement and information provision, 40. notice of discharge, 41. follow-up and aftercare, 42. record-keeping and documentation, 43. day of discharge, 44. specific groups.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
X			

Justification for this rating:

The clinical files of two residents who had been discharged and readmitted were inspected. The multidisciplinary team were involved in discharge planning. The resident and their families were involved in the discharge process and planning for care with the community mental health teams and day centre facilities. A discharge summary was sent to the GP and there was good liaison with voluntary and community groups such as the Simon community and Alcoholics Anonymous.

HOW MENTAL HEALTH SERVICES SHOULD WORK WITH PEOPLE WITH AN INTELLECTUAL DISABILITY AND MENTAL ILLNESS

Description: There was no resident in the approved centre with an intellectual disability and a mental illness.

The following aspects were considered: 5. policies, 6. education and training, 7. inter-agency collaboration, 8. individual care and treatment plan, 9.communication issues, 10. environmental considerations, 11. considering the use of restrictive practices, 12. main recommendations, 13. assessing capacity.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
	X		

Justification for this rating:

The service had a policy relating to working with individuals with an intellectual disability and a mental illness. Staff training in the management of an individual with an intellectual disability and mental illness had not taken place. The service stated that a consultant psychiatrist in the intellectual disability service was scheduled to commence one session per week in the mental health services. This was a welcome development.

Breach: 6.1

2.5 EVIDENCE OF COMPLIANCE WITH SECTIONS 60/61 MENTAL HEALTH ACT 2001 (MEDICATION)

SECTION 60 – ADMINISTRATION OF MEDICINE

Description: There was no detained patient in the approved centre longer than three months. However, there were six patients on approved leave from the approved centre, living variously at home or in community residences, all of whom continued to receive medication.

SECTION	FULLY COMPLIANT	NOT COMPLIANT
Section 60 (a)	X	
Section 60 (b)(i)	X	
Section 60 (b)(ii)	X	

Justification for this rating:

Patients had either given written consent to the continued administration of medication or had a Form 17 completed by a second consultant psychiatrist authorising its continued use.

SECTION 61 – TREATMENT OF CHILDREN WITH SECTION 25 MENTAL HEALTH ACT 2001 ORDER IN FORCE

Description: As there was no detained child in the approved centre at the time of inspection, Section 61 did not apply.

SECTION THREE: OTHER ASPECTS OF THE APPROVED CENTRE

SERVICE USER INTERVIEWS

Inspectors introduced themselves and greeted residents during the inspection. No residents sought to meet with the inspectors.

ADVOCACY

A representative from the Irish Advocacy Network (IAN) visited the DOP on a weekly basis. The IAN report for 2012 stated that “the vast majority of clients compliment the services for the care they receive. There are no major issues accessing detained residents. Staff introduce us to residents and the “blue book” is, as a rule, handed out to involuntary clients. Moreover, this information is generally available to voluntary clients as well.We have excellent links with key personal and there is no difficulty reporting issue(s) that arise. The Psychiatric Unit operates an open door policy and the Activation Unit provides welcome relief from the monotony of the wards”.

The advocate spoke by telephone with one of the inspectors and said that the staff within the DOP were approachable and very supportive in facilitating advocacy input to residents.

OVERALL CONCLUSIONS

The DOP provided in-patient care and treatment for the West Galway catchment area of approximately 121,240 people. Four general adult sector teams and the psychiatry of later life team admitted residents to the DOP. The multidisciplinary teams were better resourced with health and social care professionals in 2013 although still not adequately resourced with occupational therapists. The DOP was a busy unit and at the time of inspection six residents were on approved leave, for periods of time ranging from weeks to years. Five of the six vacated beds were then used to admit other residents. Admissions were via sector teams or the emergency department at Galway University Hospital.

The DOP did not comply with the condition attached to its registration as an approved centre in that it failed in 2013 to provide an individual care plan for each resident. The specification of therapies and treatments were not well articulated or recorded in the individual care plans. Nursing staff provided an excellent programme of activities. In the absence of ICPs, where specified therapies and treatments are linked to assessed needs, it was difficult to assess what meaningful gains a resident might make through engagement in the programmes provided. Clinical records appeared to focus on attendance and compliance. Clinical records were not well maintained and this issue had not been resolved over a three year period. There was evidence of good multidisciplinary teamwork and this resource might be used to review therapeutic programmes and service needs.

RECOMMENDATIONS 2013

1. Each resident must have an individual care plan.

2. Therapeutic services and programmes must be delivered to meet assessed needs and in accordance with the individual care plan.

3. Clinical records must be adequately maintained.

4. The seclusion room suite must not be used as a bedroom.

5. Risk assessment and management must be implemented in accordance with the approved centre’s policy.

6. Records in relation to seclusion must be in accordance with the Rules.

7. The recording of physical restraint should meet the standard of the Code of Practice.