# Report of the Inspector of Mental Health Services 2008

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| HSE AREA | Independent Sector |
| MENTAL HEALTH SERVICE | Kylemore Clinic |
| APPROVED CENTRE | Kylemore Clinic |
| NUMBER OF UNITS OR WARDS | 1 |
| UNITS OR WARDS INSPECTED | Kylemore |
| NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED | 37 |
| CONDITIONS ATTACHED TO REGISTRATION | No |
| TYPE OF INSPECTION | Announced |
| DATE OF INSPECTION | 13 May 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

Kylemore Clinic was located in Ballybrack, Dublin, and had 37 beds. There were no detained patients. On the day of the inspection there were 35 residents. Half the residents had an organic brain disease and half had a functional psychiatric disorder. It was reported that the clinic would close and move to a purpose-built unit on the grounds of Bloomfield Care Centre in March 2009. Two consultant psychiatrists had admitting rights to the clinic.

### RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

*1. Each resident should have an overall individual care plan and treatment plan.*

**Outcome:** There was no progress to report.

*2. Each resident should have a physical examination every six months as required by the Regulations.*

**Outcome:** There was no progress. It was reported that physical examinations were completed as required.

*3. Each resident should have an individual financial account and the clinic should have a written policy detailing financial procedures.*

**Outcome:** Each resident had an individual financial account. However, there was no written policy detailing financial procedures.

*4. Residents and relatives should continue to be informed about progress in relation to move.*

**Outcome:** Information was given to families and residents as appropriate to the resident's understanding.

*5. All staff should be facilitated to complete Mental Health Act 2001 training.*

**Outcome:** It was reported that a number of nursing staff had completed the training on line.

## MDT CARE PLANS 2008

There were no multidisciplinary team (MDT) care plans and there were no plans to develop them. The residents had access to nursing staff, medical staff, care staff and an occupational therapist (sessional). Two consultant psychiatrists attended the clinic weekly on set days. There were two sets of files, nursing and medical.

There was an activities of daily living (ADL) assessment on admission that was completed by the nursing staff. A nursing care plan was written. On the day of inspection, a number of review dates had passed. The notes were not dated and timed in accordance with the local policy on record writing.

There was a medical file. In the files reviewed there was no evidence of formal psychiatric reviews and general health reviews being completed in a timely manner.

The occupational therapist wrote continuation notes in the nursing file. There was no evidence in the file reviewed of completed assessments.

There was no evidence of involvement of the residents in care planning. Unmet need was not recorded. No team meetings were held.

## GOOD PRACTICE DEVELOPMENTS 2008

- All registered nurses had completed online training on the Mental Health Act 2001.

## SERVICE USER INTERVIEWS

A number of residents were spoken to informally during the inspection. They reported satisfaction with the care and treatment provided.

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

1. Each resident should have an overall individual care plan and treatment plan.

2. Each resident should have a physical examination every six months as required by the Regulations.

3. Each resident should have a psychiatric examination at regular intervals.

4. The clinic should have a written policy detailing financial procedures.

5. Residents and relatives should continue to be informed about progress in relation to the move.

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

## INTRODUCTION

In 2008, the inspection focused on areas of non-compliance identified in 2007. In addition, the Inspectorate re-inspected compliance with all the articles in part three of the Regulations (15–21 and 26) and the Rules and the Codes of Practice in each approved centre. In 2008, two new codes of practice were issued and compliance with them was inspected. Where conditions were attached, they were inspected in detail. Evidence of compliance was established through three strands:

- Inspection of compliance where there was a breach in 2007. This was cross-referenced with the action plan submitted to the MHC Standards and Quality Assurance Division.
- Written evidence requested prior to the inspection, for example policies.
- Evidence gathered during the course of the inspection from staff, service users, photographic evidence and photocopies.

## 2.1 EVIDENCE OF COMPLIANCE WITH CONDITIONS ATTACHED TO REGISTRATION

As no conditions were attached, this was not applicable.

## 2.2 EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d) ON 13 MAY 2008

### Article 6 (1-2) Food Safety

The service was compliant with this Article.

**Compliant:** Yes

### Article 8: Residents' Personal Property and Possessions

The service was compliant with this Article. The service submitted a written policy detailing financial procedures on residents' personal finance.

**Compliant:** Yes

### Article 12 (1-4): Communication

The service was compliant with this Article.

**Compliant:** Yes

### Article 13: Searches

The service was compliant with this Article.

**Compliant:** Yes

### Article 15: Individual Care Plan

Individual care plans, as defined in the Regulations, were not in place.

**Breach:** Article 15

**Compliant:** No

### Article 16: Therapeutic Services and Programmes

The programmes were not linked to the resident's individual care plan. Not all residents could attend these programmes.

**Breach:** Article 16 (1)

**Compliant:** No

### Article 17: Children's Education

The clinic did not admit children.

**Compliant:** Not applicable

### Article 18: Transfer of Residents

The service was compliant with this Article.

**Compliant:** Yes

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

There was no evidence in the notes that each resident had a full physical examination as defined.

**Breach:** Article 19 (1)(b)

**Compliant:** No

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

No written policy and procedures were in place for the provision of information to residents. Following factual correction, the service subsequently forwarded a policy. Residents had not been given access to written information about their illness.

**Breach:** Article 20 (1)

**Compliant:** No

### Article 21: Privacy

The service was compliant with this Article.

**Compliant:** Yes

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

There was no policy on prescribing medication. The service subsequently forwarded a policy on prescribing medication.

**Compliant:** Yes

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

CCTV was not used.

**Compliant:** Not applicable

## Article 26: Staffing

The service had no written policies and procedures relating to the recruitment, selection and vetting of staff. There was an unmet need for a physiotherapy service. There was no registered psychiatric nurse employed by the service.

A director of nursing had overall responsibility for the care of the residents in the approved centre. In her absence, one of the two CNMs took charge of the approved centre during the day. The CNMs rotated with each other. At night time, a registered general nurse was in charge of the care in the approved centre.

| STAFF TYPE | DAY | EVENING | NIGHT |
|---|---|---|---|
| Registered General Nurse | 2 to 4 | 2 | 1 |
| Registered Psychiatric Nurse | 0 | 0 | 0 |
| Care worker | 5 to 7 | 3 | 3 |
| Occupational therapist | Sessional (4/5 days) | – | – |

**Breach:** Article 26 (1), Article 26 (2), Article 26 (3)

**Compliant:** No

## Article 27: Maintenance of Records

There were no policies for creation, access to, or retention and destruction of records.

**Breach:** Article 27 (2)

**Compliant:** No

## Article 29: Operating policies and procedures

A number of policies that were required under the Regulations were not available. They are reported individually under each Article.

**Breach:** Article 29

**Compliant:** No

## Article 30: Mental Health Tribunals

The clinic did not accept detained patients.

**Compliant:** Not applicable

## Article 32: Risk Management Procedures

The service was compliant with this Article.

**Compliant:** Yes

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

### SECLUSION

The service reported that seclusion was not used. A policy stating that this is practice was requested by the Inspectorate. A policy was subsequently sent to the Inspectorate stating that seclusion was not used.

**Compliant:** Not applicable

### ECT

The service reported that ECT was not used.

**Compliant:** Not applicable

### MECHANICAL RESTRAINT

The service reported that mechanical restraint was not used on the unit. A policy stating that this is practice must be sent to the inspectorate. A policy was subsequently sent to the Inspectorate stating that mechanical restraint was not used.

| SECTION | DESCRIPTION | COMPLIANCE REPORT |
|---|---|---|
| **21** | **Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour** | A lap seatbelt and cot sides on beds were used for preventing enduring self-injurious behaviour [Article 21 (4)]. Part 5 of the Rules, which applied in these instances, were not fully complied with, as it was not prescribed by the consultant psychiatrist. Subsequent to the inspection, the service submitted evidence that a prescription sheet will be placed in each relevant clinical file. |

**Breach:** Section 21 (4)

**Compliant:** No

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

### PHYSICAL RESTRAINT

The Inspectorate was informed that no form of physical restraint was in use in the clinic. A policy stating that this was practice was requested by the Inspectorate. A policy was subsequently sent to the Inspectorate stating that physical restraint was not used.

**Compliant:** Not applicable

### ADMISSION OF CHILDREN

The unit did not admit children.

**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 provided.

**Compliant:** Not applicable

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

This was not applicable as there were no detained patients.

**Compliant:** Not applicable