# Report of the Inspector of Mental Health Services 2008

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|---|---|
| HSE AREA | HSE West |
| CATCHMENT | Clare |
| MENTAL HEALTH SERVICE | Clare |
| APPROVED CENTRE | Orchard Grove |
| NUMBER OF UNITS OR WARDS | 1 |
| UNITS OR WARDS INSPECTED | Orchard Grove |
| NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED | 10 |
| CONDITIONS ATTACHED TO REGISTRATION | No |
| TYPE OF INSPECTION | Announced |
| DATE OF INSPECTION | 8 July 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. The Inspectorate met with the CNM 2 and consultant psychiatrist on the unit. A feedback meeting was facilitated following the inspection, and this was attended by a number of clinical staff and managers.

### DESCRIPTION

Orchard Grove was situated on the grounds of an old hospital. It was a single-storey building with a private and enclosed outdoor space at the back. It was near the centre of the town, allowing easy access for residents.

| WARD | NUMBER OF BEDS | NUMBER OF RESIDENTS | TEAM RESPONSIBLE |
|---|---|---|---|
| Orchard Grove | 10 | 8 | Rehabilitation |

The Inspectorate commended the staff attached to Orchard Grove on the amount of work that had been completed since the last inspection in order to address the issues of non-compliance identified in last year's Report, particularly in relation to individual care plans and policies.

### RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

*1. A review should be undertaken to establish if this centre should continue to be licensed as an approved centre under the Mental Health Act 2001. This review should take into account the current and future needs of residents and the wider model of service delivery.*

**Outcome:** The status of the unit in relation to the Mental Health Act 2001 was discussed regularly at senior management level. The unit continued to operate as an approved centre under the care of the rehabilitation team. There were plans to integrate the service, with two female residents being considered for transfer from elsewhere in the mental health service.

*2. The approved centre should develop policies, procedures and protocols relating to the Regulations, Rules and Codes of Practice that reflect local practice.*

**Outcome:** The approved centre had a comprehensive number of policies as required by the Regulations, Rules and Codes of Practice and these were all localised for Orchard Grove.

*3. All registers and clinical practice forms relating to the Rules and Codes of Practice should be kept within the approved centre.*

**Outcome:** Physical restraint was not used on the unit but the clinical practice forms were available if required. Seclusion, ECT and mechanical restraint were not used on the unit.

*4. The rehabilitation team should develop a multidisciplinary care plan for each resident and set a review date.*

**Outcome:** The team had assessed the majority of residents using the Functional Analysis of Care Environment (FACE) assessment, which led to comprehensive MDT care plans.

*5. All residents should have a physical examination every six months.*

**Outcome:** On the day of inspection, all residents had had a six-monthly physical examination.

*6. A health and safety statement for the approved centre should be developed.*

**Outcome:** This was in place.

*7. The remaining structural/maintenance work must be completed.*

**Outcome:** Painting was in progress on the day of inspection. The toilet system had been removed and was been replaced by a new system and space had been created to include a shower area.

## MDT CARE PLANS 2008

The approved centre used the FACE assessment system and individual care plans were developed on the basis of these assessments. For residents who were able to be actively involved, the care plans included a section for them to complete in relation to their views about their own needs and treatment.

On the day of inspection all of the residents, except one, had an individual care plan. The care plans reviewed in the clinical files had been reviewed every four to five months and they had all been recently reviewed. The service reported that the care plans were discussed and reviewed regularly at the multidisciplinary team meetings at which all disciplines on the team were involved.

Minutes of the team meetings were not available on the day of inspection and the involvement of other members of the team in care planning was not documented in the clinical files. Subsequently the service reported that all staff documented their interventions in the care plan. The one resident who did not have a care plan was receiving care in another hospital at the time of the inspection.

## GOOD PRACTICE DEVELOPMENTS 2008

- Introduction of individual care plans based on completed FACE assessments.
- Development of a comprehensive set of localised policies.
- The continued development of a rehabilitation model promoting social inclusion.

## SERVICE USER INTERVIEWS

A number of residents spoke informally to the Inspectorate.

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

1. The policy on Provision of Information to Residents should be implemented in full.

2. Each resident must have an individual care plan.

# 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 8 JULY 2008

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

Food safety reports were reviewed by the Inspectorate and were in order.

**Compliant:** Yes

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

The unit had a policy on residents' personal property and possessions implemented in November 2007 and due for review in November 2010. The centre had implemented a property book that contained an up-to-date list of each resident's property and possessions.

**Compliant:** Yes

### Article 11 (1-6): Visits

Although the unit did not have designated visiting rooms, there were several areas that could be used for visits. These included the dining room, activity room or one of the sitting rooms. A policy on visits, implemented in November 2007, was due for review in November 2010.

**Compliant:** Yes

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

The unit had a policy on communication, implemented in November 2007 and due for review in November 2010.

**Compliant:** Yes

## Article 13: Searches

The unit had a policy and procedures in place for the carrying out of searches, implemented in November 2007 and due for review in November 2010. It was reported by the nursing staff that searches did not take place.

**Compliant:** Yes

## Article 15: Individual Care Plan

Each resident has had a standardised assessment of need using the FACE assessment. The assessments had been used to form the basis of the individual care plan. One resident did not have an individual care plan. Subsequently it was reported that this resident was receiving care in another hospital, and that his care plan has been amended to reflect this.

**Compliant:** Yes

## Article 16: Therapeutic Services and Programmes

Therapeutic activities were linked to the FACE assessments. Although there was no structured programme in place, a range of activities that centred on the individual choice of the residents and on social inclusion was in place. There were plans to develop a kitchen area for the residents to prepare meals.

**Compliant:** Yes

## Article 17: Children's Education

Children were not admitted to this approved centre.

**Compliant:** Not applicable

## Article 18: Transfer of Residents

The approved centre had policy and procedures in place for the transfer of residents implemented in November 2007 and due for review in November 2010.

**Compliant:** Yes

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

In the clinical files reviewed, there was evidence of six-monthly reviews of physical health having been completed. The approved centre had a policy and procedures for responding to medical emergencies implemented in November 2007 and due for review in 2010.

**Compliant:** Yes

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

The unit had a policy and procedures in place for the provision of information to residents. Following the inspection, the service amended the policy to include a procedure for ensuring that typed information relevant to the resident's diagnosis was provided unless prejudicial to the health and welfare of the resident or another person.

**Breach:** The approved centre was not routinely providing written information on diagnosis to residents [Article 20 (1)(c)].

**Compliant:** No

## Article 21: Privacy

A number of residents had their own single room and shared rooms contained a maximum of two residents. Residents had their own wardrobes and lockers and there was adequate space for them to have private time away from other residents.

**Compliant:** Yes

## Article 22: Premises

The unit was undergoing a programme of redecoration at the time of the inspection. The toilet facilities were being upgraded and a new shower was on order. The premises were clean and maintained in a good condition and were adequately lit, heated and ventilated.

**Compliant:** Yes

## Article 24 (1-2): Health and Safety

The unit had a comprehensive health and safety statement**.**

**Compliant:** Yes

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

There was no CCTV in operation within the unit.

**Compliant:** Not applicable

## Article 26: Staffing

All staff were recruited through the central HSE recruitment process. On the day of the inspection, one CMN2 and three staff nurses were on duty by day and two staff nurses were on duty at night. It was reported that the third staff nurse was rarely in place on the unit due to staffing demands elsewhere in the service. The nursing staff on duty during the day and at night within the approved centre can access the assistant director of nursing for Clare Mental Health Services. Residents had access to the rehabilitation team, which had a social worker, consultant psychiatrist, clinical psychologist, occupational therapist and community nurses.

The nursing staff accessed the general training programme for the wider service. All had received training in the Mental Health Act 2001.

**Compliant:** Yes

## Article 27: Maintenance of Records

The approved centre was compliant with this Article.

**Compliant:** Yes

## Article 28: Register of Residents

The register of residents contained all the information required in this Article.

**Compliant:** Yes

## Article 29: Operating policies and procedures

All of the policies required under the Regulations, Rules and Codes of Practice were available on the unit and had been localised to the approved centre. The policies all had a date of implementation and a date when they were due for review.

**Compliant:** Yes

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

### SECLUSION

Staff reported that seclusion was not used and there were no seclusion facilities and the policy confirmed this. The Inspectorate draws attention to Section 9.1(d) of these Rules which requires the policy to be reviewed at least annually.

**Compliant:** Not applicable

### ECT

There were no facilities within the approved centre for ECT and there were no detained patients in the approved centre. The approved centre had a policy that ECT was not used.

**Compliant:** Not applicable

### MECHANICAL RESTRAINT

Staff reported that mechanical restraint was not used in the approved centre and the policy confirmed this. The policy was implemented in November 2007 and had a review date for November 2010. The Inspectorate draws attention to Section 18 (1)(d) of these Rules which requires the policy to be reviewed at least annually.

| SECTION | DESCRIPTION | COMPLIANCE REPORT |
|---|---|---|
| **21** | **Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour** | This was not used in the unit. |

**Compliant:** Not applicable

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

### PHYSICAL RESTRAINT

It was reported that physical restraint had not been used in the unit and there was no record of any physical restraint having being applied. The unit had a policy on the use of physical restraint, implemented in November 2007 with a date for review in November 2010. The Inspectorate draws attention to Section 6.1(d) of this Code of Practice, which requires the policy to be reviewed at least annually.

**Compliant:** Not applicable

### ADMISSION OF CHILDREN

Children were not admitted to this approved centre.

**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

No voluntary patient from Orchard Grove had received ECT. Staff reported that ECT was not used and there were no ECT facilities in the approved centre. The approved centre had a policy stating that ECT was not used.

**Compliant:** Not applicable

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

Section 61 was not applicable as the approved centre did not admit children. Section 60 was not applicable as there were no detained patients in the approved centre.

**Compliant:** Not applicable