Report of the Inspector of Mental Health Services 2010

EXECUTIVE CATCHMENT AREA	Galway Mayo Roscommon
HSE AREA	West
CATCHMENT AREA	Galway
MENTAL HEALTH SERVICE	East Galway
APPROVED CENTRE	St. Brigid's Hospital, Ballinasloe
NUMBER OF WARDS	5
NAMES OF UNITS OR WARDS INSPECTED	Ward 17 Ward 21 St. Dympna's Ward Our Lady's Ward St. Luke's Ward
TOTAL NUMBER OF BEDS	77
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	18 May 2010

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

INTRODUCTION

In 2010, the Inspectorate paid particular attention to Articles 15 to 22 and 26 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 and all areas of non-compliance with the Regulations in 2009 and any other Article where applicable. 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 2009. Information was gathered from self-assessments, service user interviews, staff interviews and photographic evidence collected on the day of the inspection.

DESCRIPTION

St. Brigid's Hospital, Ballinasloe, was an approved centre under the Mental Health Act (2001) and was part of a wider community mental health service. The acute units of St. Dympna's, St. Luke's and Our Lady's ward were situated across the road from the main hospital building which still accommodated Wards 17 and 21. Since the 2009 inspection Ward 19 with 17 beds had closed and residents had been integrated with Ward 21 and the new Community Nursing Unit. The total number of beds in the approved centre had been reduced from 94 beds in 2009 to 77 beds at the time of inspection. There were well advanced plans to close Our Lady's ward in the near future and to move Ward 17 into Our Lady's ward after some refurbishment.

DETAILS OF WARDS IN THE APPROVED CENTRE

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Ward 17	13	13	Rehabilitation
Ward 21	19	17	Psychiatry of Old Age
St. Dympna's	20	17	General Adult
Our Lady's	15	15	General Adult
St. Luke's	10	10	General Adult

QUALITY INITIATIVES

- An audit of medication was carried out with the result that the medication Kardex was redesigned.
- A catchment wide Policy Group which included service users was set up recently.
- The CORE (Clinical Outcomes in Routine Evaluation) assessment was introduced for all acute admissions.
- The rehabilitation team had an Advanced Nurse Practitioner in psychosis.
- A Memory Clinic was established in conjunction with a geriatrician in Portiuncla Hospital.
- Ward 19 had been closed.

PROGRESS ON RECOMMENDATIONS IN THE 2009 APPROVED CENTRE REPORT

1. A consultant in rehabilitation should be appointed.

Outcome: This had been achieved.

2. Integrated care plans should be introduced.

Outcome: New integrated care plans were being introduced throughout the approved centre.

3. Input from occupational therapists in the long-stay wards should be increased to enhance the recovery programme for residents.

Outcome: The rehabilitation team had appointed a 0.3 whole-time-equivalent Occupational Therapy Manager and the Psychiatry of Old Age had regular input from the Occupational Therapist.

4. If seclusion continues to be used, consideration should be given to upgrading the facility, perhaps by incorporating the second seclusion room as bathroom facilities for the remaining room.

Outcome: Capital funding had been secured which will ensure that the facilities are upgraded in the near future.

5. Seclusion rooms should not be used as bedrooms.

Outcome: The Inspectorate were informed that the seclusion rooms were not used as bedrooms but on occasion, a resident may request use of the room as a quiet room.

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

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 5: Food and Nutrition

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 6 (1-2): Food Safety

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 7: Clothing

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 8: Residents' Personal Property and Possessions

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 9: Recreational Activities

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 10: Religion

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 11 (1-6): Visits

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 12 (1-4): Communication

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 13: Searches

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

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

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 15: Individual Care Plan

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*	X	X
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

Ward 17: Residents had a multidisciplinary Recovery care plan.

St. Luke's Ward: Many residents did not have individual care plans as described in the Regulations.

Breach: 15

Article 16: Therapeutic Services and Programmes

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*	X	X
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

Ward 17: The occupational therapist attended the ward one day per week. Two residents attended the Training Centre daily.

St. Luke's Ward: One hour of occupational therapy was provided on the ward each week. Other therapeutic services and programmes were provided in the Activities unit in the building by nursing staff. Therapeutic services and programmes were not linked to individual care plans in many instances.

Breach: 16 (1)

Article 17: Children's Education

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

One child had been admitted in 2010 to date. The approved centre stated that if educational facilities were indicated for any child admitted, it would endeavour to meet those needs.

Article 18: Transfer of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

The approved centre had a policy on transfer of residents. A letter of referral was written by the medical officer and staff accompanied residents being transferred.

Article 19 (1-2): General Health

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

Ward 17: The clinical files of three residents were examined and there was evidence that physical health reviews had been carried out within the previous six months.

St. Dympna's Ward: The clinical files of two residents were examined and there was evidence that physical health reviews had been carried out within the previous six months.

Our Lady's Ward: No resident had remained on the ward for longer than six months.

St. Luke's Ward: One clinical file was examined and the resident had refused their six-monthly physical review. This was clearly stated in the clinical files.

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

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

The approved centre had a policy on provision of information to residents. An information booklet was available on the wards.

Article 21: Privacy

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*	**X**	**X**

Justification for this rating:

The approved centre had a number of double rooms and many of these had no partitioning curtains for privacy. There were glass panels in the doors of the single rooms in St. Luke's ward and in the doors of the seclusion rooms which afforded no privacy. The doors of the toilets in St. Dympna's ward were not full size and provided no privacy when in use.

Breach: 21

Article 22: Premises

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*	X	X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

Although much of the approved centre was very old, the unit was very clean. Some of the bathroom areas were in poor condition.

Breach: 22 (1)

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

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 24 (1-2): Health and Safety

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 25: Use of Closed Circuit Television (CCTV)

CCTV was not used by the approved centre for the observation of residents.

Article 26: Staffing

WARD OR UNIT	STAFF TYPE	DAY	NIGHT
Ward 17	Nurse	2	2
	Multi-task Attendant	1	0
Ward 21	Nurse	4	3
	Multi-task Attendant	3	0
St. Dympna's Ward	Nurse	4	3
	Multi-task Attendant	2	0
Our Lady's Ward	Nurse	3	2
	Multi-task Attendant	3	0
St. Luke's Ward	Nurse	4	3-4
	Multi-task Attendant	1-2	0

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*	X	
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

A consultant psychiatrist in rehabilitation had been appointed and the service now had a full multidisciplinary rehabilitation team. One occupational therapist provided a service for residents in the approved centre. A senior member of nursing staff was on duty at all times. The service followed the Health Service Executive policy on recruitment and vetting of staff.

Breach: 26 (2)

Article 27: Maintenance of Records

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

Records of food safety, health and safety and fire safety inspections were not available to the Inspectorate.

Breach: 27 (3)

Article 28: Register of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 29: Operating policies and procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 30: Mental Health Tribunals

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 31: Complaint Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*	X	
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

The approved centre had a policy on complaints. The nominated person was located in the area manager's office and not in the approved centre.

Breach: 31 (4)

Article 32: Risk Management Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

The approved centre did not have a comprehensive risk management policy as specified in the Regulations. A record of incidents was forwarded to the Mental Health Commission at regular intervals.

Breach: 32 (1)

Article 33: Insurance

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 34: Certificate of Registration

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

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

SECLUSION

Use: There were two seclusion rooms situated in St. Luke's ward. At the time of inspection, St. Luke's ward had 13 episodes of seclusion on four residents. Both of the beds in the seclusion room were made up and it was reported that the rooms were occasionally used at night by residents who requested the room for privacy and quietness away from the dormitory style bedrooms.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
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		X		
13	Child patients	NOT APPLICABLE			

Justification for this rating:

There was no CCTV signage outside the seclusion room to inform the patient that they were being monitored. There was a transparent panel on the door of the seclusion room which was unsafe and should be replaced. The bed frame in the seclusion room was wooden and a potential hazard for patients who were secluded.

The clinical file of one resident was examined in conjunction with the seclusion register. The seclusion register did not record the time seclusion ended and there was no information in the clinical file.

Breach: 4.3, 7.2, 8.3, 12.2(b)

ECT (DETAINED PATIENTS)

Use: One detained patient had received ECT in 2010 but their detention had been revoked after the first treatment. No detained patient was receiving ECT at the time of inspection.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	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	X			
13	ECT during pregnancy	NOT APPLICABLE			

Justification for this rating:

The ECT suite was spacious and comprised a waiting room, a treatment room and a recovery room. There were two trained designated ECT nurses and one consultant designated for ECT.

MECHANICAL RESTRAINT

Use: Mechanical restraint was not used in the approved centre except in cases for enduring risk of harm to self or others.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
14	Orders	NOT APPLICABLE			
15	Patient dignity and safety	NOT APPLICABLE			
16	Ending mechanical restraint	NOT APPLICABLE			
17	Recording use of mechanical restraint	NOT APPLICABLE			
18	Clinical governance	NOT APPLICABLE			
19	Staff training	NOT APPLICABLE			
20	Child patients	NOT APPLICABLE			
21	Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour	X			

Justification for this rating:

Ward17: Mechanical restraint under Part 5 was not used.

Ward 21: Two residents were restrained by means of lap belts. The clinical files of these residents had a record of their use.

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

PHYSICAL RESTRAINT

Use: At the time of inspection, St. Dympna's ward had four episodes of physical restraint on four residents and St. Luke's ward had 21 episodes of physical restraint on five residents.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
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:

Ward 17: There had been one episode of physical restraint in Ward 17 in 2010. The Clinical Practice Form had not been completed by the consultant and was still in the Physical Restraint Clinical Practice Form book.

St. Dympna's Ward: The clinical file of one resident and the Clinical Practice Forms for Physical Restraint were examined. The Form in the Clinical Practice Form book for Physical Restraint had not been completed for Section 18 but the episode had been documented in the clinical file.

St Luke's Ward: On three occasions the Physical Restraint Clinical Practice Form book was incomplete for Sections 16 and 17.

Breach: 5.7(a), 7, 8.2, 8.3

ADMISSION OF CHILDREN

Description: No children were resident on the day of inspection. St. Dympna's had two children admitted and St. Luke's ward had one child admitted from the beginning of 2010 to the date of the inspection. No clinical files were available to be examined on the day of inspection.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
2	Admission				X
3	Treatment	X			
4	Leave provisions	X			

Justification for this rating:

The approved centre was unsuitable for the admission for children.

Breach: 2.5

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

Description: Two residents had died in 2010 but had been transferred to Portiuncla Hospital prior to the death. The approved centre provided notification of any deaths or incidents every six months to the Mental Health Commission.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
2	Notification of deaths	X			
3	Incident reporting	X			
4	Clinical governance		X		

Justification for this rating:

Deaths were reported to the Mental Health Commission. The approved centre maintained a record of incidents based on the STARSWEB system and a record of incidents was provided to the Mental Health Commission at six monthly intervals. The approved centre did not have a comprehensive risk management policy as specified in the Regulations.

Breach: 4

ECT FOR VOLUNTARY PATIENTS

Use: The ECT facilities at St. Brigid's Hospital provided an excellent service for residents.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
4	Consent	X			
5	Information		X		
6	Prescription of ECT	X			
7	Assessment of voluntary patient	X			
8	Anaesthesia	X			
9	Administration of ECT	X			
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 evidence in the clinical file of the resident receiving ECT that consent had been obtained. A checklist of necessary items had been completed prior to the treatment. The register for ECT was correctly completed and the clinical file contained a record of ECT administered. The resident's clinical status had been checked before commencing ECT. Although the service had an information leaflet on ECT, there was no evidence in the clinical file that such information had been provided to the resident. There were two nurses trained in ECT and one designated consultant.

Breach: 5

ADMISSION, TRANSFER AND DISCHARGE

Description: A number of clinical files and the policies of the approved centre were reviewed.

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	COMPLIANCE INITIATED	NOT COMPLIANT
	X		

Justification for this rating:

The approved centre had policies on admission, involuntary admission, transfer and discharge of residents. There were procedures for admission and assessments at the time of admission. The roles of staff were clearly described in the policy and staff were familiar with the protocols. The approved centre did not have a comprehensive risk management policy as specified in the Regulations.

Breach: 7

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	COMPLIANCE INITIATED	NOT COMPLIANT
	X		

Justification for this rating:

Procedures for admission were established within the approved centre. The admission policy did not describe procedures in the event of a person self-referring to the approved centre, or the protocol relating to the decision not to admit. There was no protocol for admitting homeless people. There were clear procedures for admitting involuntary patients. Following admission, residents had a CORE (Clinical Outcomes in Routine Evaluation) assessment and physical examination carried out. The procedure specified that the ward information booklet should be given to the resident and a record of personal property. On review of clinical files, there was evidence that many residents did not have individual care plans as described in the Regulations.

Breach: 11.2, 14, 17, 24

Part 4 Transfer Process

The following aspects were considered: 25. Transfer criteria, 26. decision to transfer, 27. assessment before transfer, 28. resident involvement, 29. multi-disciplinary 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	COMPLIANCE INITIATED	NOT COMPLIANT
X			

Justification for this rating:

The approved centre had a policy on transfer of residents. Procedures for transferring residents were clearly described in the policy. A referral letter was written by the medical staff and a nurse accompanied the resident to the hospital. The nurse remained with the resident until admission to the new approved centre or hospital.

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	COMPLIANCE INITIATED	NOT COMPLIANT
	X		

Justification for this rating:

The approved centre had comprehensive policies on the discharge of residents and involuntary patients. The protocol for discharge included assessment by the multidisciplinary team prior to discharge, informing next-of-kin (with the consent of the resident), and provided for information to be sent to the resident's general practitioner. The policy did not make specific the protocols for the discharge of homeless or elderly persons.

Breach: 44

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

Description: There were a number of residents in St. Brigid's Hospital with an intellectual disability and mental illness. The clinical files of two of these residents were reviewed, one of whom had been admitted the previous month.

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	COMPLIANCE INITIATED	NOT COMPLIANT
		X	

Justification for this rating:

The approved centre did not have a policy on working with people with an intellectual disability and mental illness and there were no arrangements providing for specific education for staff in relation to intellectual disability and mental illness. One of the residents had an individual care plan and both had a risk assessment carried out. No correspondence had been received from the intellectual disability service involved in the care of one of the residents and an assessment of needs had been conducted in the case of the other resident.

Breach: 5, 6, 7, 8

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

SECTION 60 – ADMINISTRATION OF MEDICINE

Description: On St. Luke's ward there were five detained patients and one detained patient on St. Dympna's. All the clinical files of detained patients were examined and were fully compliant with Section 60.

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

Justification for this rating:

All the clinical files of detained patients were examined and were fully compliant with Section 60.

SECTION 61 – TREATMENT OF CHILDREN WITH SECTION 25 ORDER IN FORCE

Description: At the time of inspection there were no children admitted to the approved centre, therefore Section 61 did not apply.

SECTION THREE: OTHER ASPECTS OF THE APPROVED CENTRE

SERVICE USER INTERVIEWS

All residents were greeted by the Inspectorate as they conducted the inspection, but no resident requested to speak directly with the Inspectorate.

MEDICATION

The medication prescriptions were in Kardex format. The prescriptions were mainly legible although a number of signatures were illegible. As required (PRN) prescriptions were mixed with regular prescriptions. In most cases no indication for PRN medication was given.

MEDICATION ACUTE

NUMBER OF PRESCRIPTIONS:	42
Number on benzodiazepines	22 (52%)
Number on more than one benzodiazepine	6 (14%)
Number on regular benzodiazepines	11 (26%)
Number on PRN benzodiazepines	17 (40%)
Number on hypnotics	22 (52%)
Number on Non benzodiazepine hypnotics	19 (45%)
Number on antipsychotic medication	35 (83%)
Number on high dose antipsychotic medication	1 (2%)
Number on more than one antipsychotic medication	13 (31%)
Number on PRN antipsychotic medication	12 (29%)
Number on antidepressant medication	22 (52%)

Number on more than one antidepressant	**1 (2%)**
Number on antiepileptic medication	**10 (24%)**
Number on Lithium	**8 (19%)**

MEDICATION LONG STAY

NUMBER OF PRESCRIPTIONS:	**30**
Number on benzodiazepines	**22 (73%)**
Number on more than one benzodiazepine	**7 (23%)**
Number on regular benzodiazepines	**15 (50%)**
Number on PRN benzodiazepines	**14 (47%)**
Number on hypnotics	**15 (50%)**
Number on Non benzodiazepine hypnotics	**5 (17%)**
Number on antipsychotic medication	**26 (87%)**
Number on high dose antipsychotic medication	**3 (10%)**
Number on more than one antipsychotic medication	**15 (50%)**
Number on PRN antipsychotic medication	**7 (23%)**
Number on antidepressant medication	**12 (40%)**
Number on more than one antidepressant	**2 (7%)**

Number on antiepileptic medication	**11 (37%)**
Number on Lithium	**2 (7%)**

OVERALL CONCLUSIONS

There was good evidence that staff were enthusiastic and provided a very good level of clinical care for residents. It was encouraging to see that the closure plans for the older part of the approved centre were progressing and that overall bed numbers were decreasing. The premises were relatively well maintained but the Inspectorate continued to be concerned about the lack of privacy in some areas, particularly the toilet areas in St. Dympna's ward. Whilst some residents, particularly those under the care of the rehabilitation team had good individual care plans, other residents did not have individual care plans as described in the Regulations. Provision of therapeutic services and programmes were variable with some residents having little therapeutic input. The number of prescriptions for regular and as required (PRN) benzodiazepines in the continuing care wards was high.

RECOMMENDATIONS 2010

1. All residents should have individual care plans as described in the Regulations.

2. The issues regarding lack of privacy should be addressed immediately.

3. Policies and procedures should be developed in order to bring the service into compliance with the Codes of Practice on Admission, Transfer and Discharge to and from An Approved Centre and Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities.

4. A review of medication in the continuing care wards should take place.