Report of the Inspector of Mental Health Services 2010

EXECUTIVE CATCHMENT AREA	South Lee/West Cork/Kerry
HSE AREA	South
CATCHMENT AREA	Kerry
MENTAL HEALTH SERVICE	Kerry
APPROVED CENTRE	St. Finan's Hospital, Killarney
NUMBER OF WARDS	5
NAMES OF UNITS OR WARDS INSPECTED	St. Peter's Ward St. Paul's Ward St. Martin's Ward O'Connor Unit East O'Connor Unit West
TOTAL NUMBER OF BEDS	52
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	24 June 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

Three of the five operational wards in this approved centre were located in the main hospital, a large grey-bricked building on the outskirts of Killarney town which was built in 1849. Many of the wards were now closed and the emptiness resonated around the large rambling building on the day of inspection. High ceilings, large open internal spaces and drab surroundings made the provision of personalised care in keeping with modern requirements very difficult, in spite of the efforts made by staff. New paintwork could not disguise the dampness in the building, which the Inspectorate were told was difficult and costly to maintain and heat. Some single rooms had interior and exterior doors which made them appear more like cells. Some patients were in a large open dormitory with beds situated in the centre of the room, with little privacy. New furnishings had been provided during the year which improved the appearance and comfort level for residents. In some wards residents had very little to do and there was no programme of therapeutic services and programmes for those who could not attend outside services and programmes. Shortage of nursing staff meant that on the day of this unannounced inspection, covering staff were not familiar with ward systems. All wards were inspected. Compliance with the Regulations, Rules and Codes of Practise were inspected on St. Peter's Ward and St. Paul's Ward.

DETAILS OF WARDS IN THE APPROVED CENTRE

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
St. Peter's Ward	10	10	Rehabilitation
St. Paul's Ward	10	10	General Adult
St. Martin's Ward	9	9	Rehabilitation
O'Connor Unit East	12	12	Rehabilitation
O'Connor Unit West	12	11	Rehabilitation

(Bed numbers supplied by service)

QUALITY INITIATIVES

- St. Peter's and St. Paul's wards had been painted. St. Martin's ward was being painted on the day of inspection.
- New sinks had been provided in the patients' toilets and sluice room in St. Peter's Ward.
- Some new chairs had been provided for the Wards.
- New dining tables and chairs had been provided in the O'Connor Units.
- New mattresses and duvet covers had been ordered in St. Martin's ward.
- En suite facilities had been provided for three rooms in the O'Connor East Ward.
- New sinks had been provided in four dormitories in the O'Connor Units.
- Pictures had been hung on the walls in the O'Connor Units.

PROGRESS ON RECOMMENDATIONS IN THE 2009 APPROVED CENTRE REPORT

1. St. Finan's Hospital should close.

Outcome: St. Finan's Hospital was still open. Plans existed for the building of a 25-bed continuing care and challenging behaviour unit for older persons with mental health problems, a 15-bed intensive care rehabilitation unit, and a 10-bed community residence for remaining residents. There was no indication that capital funding was forthcoming to proceed with these plans.

2. The rehabilitation team should fill its vacant posts. Each post should be full time with the team.

Outcome: This had not happened. The moratorium on recruitment continued.

3. A Psychiatry of Old Age team should be appointed.

Outcome: This had not happened.

4. The residents of St. Peter's ward must have their right to privacy and dignity appropriately respected. The ongoing issues relating to privacy are being worsened unacceptably by overcrowding on St. Peter's ward.

Outcome: One resident was still sleeping in a corridor.

5. Seclusion rooms must not be used as bedrooms.

Outcome: The seclusion room in St. Martin's ward was being used as a bedroom.

6. St. Paul's ward must implement an individual care plan for each resident, as defined in the Regulations.

Outcome: This had not happened.

7. Nursing personnel should cease wearing white coats as this only serves to give the impression to anyone who visits the hospital that the type of care being delivered to residents was institutionally focused rather than focused on the progressive care to be expected in the 21st century.

Outcome: Staff reported that white coats were no longer being worn.

8. Therapeutic services and programmes must be linked to the resident's individual care plan.

Outcome: There was little evidence of any therapeutic programmes occurring on St. Peter's Ward. St. Paul's ward did not have individual care plans.

9. A policy on the transfer of residents should be implemented.

Outcome: This had been achieved.

10. Information must be provided to residents in accordance with the policy.

It was reported by staff on St Peter's ward that there were no information leaflets on St. Peter's ward. In the feedback meeting following inspection, the senior management team indicated to the Inspectorate that information leaflets were available on St. Peter's ward. This scenario was a repeat of last year, during the 2009 inspection, when no such leaflets could be found on St. Peter's ward and when senior management were adamant that they were there. The activities notice board in St. Paul's ward was blank; it was pointed out to the Inspectorate by a member of staff that the white board marker was dry. There was an information leaflet in St. Paul's ward. Print was small and, given the population, would not be of benefit to them. A well produced leaflet would be of benefit to residents' visiting relatives. There was no written information available on medication on either ward. Senior staff, prior to the inspection, reported to the Inspectorate team that information on medications was available online if needed. However, staff on the ward did not seem to be aware of this.

11. The approved centre must have general policies on the prescribing, ordering, storing and administration of medication.

Outcome: This had been achieved.

12. The risk management policy should be in accordance with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting.

Outcome: This had not been achieved.

13. The seclusion policy must be reviewed annually.

Outcome: This was being complied with.

14. The use of Part 5 of the mechanical restraint Rules should include a date of review and duration of use.

Outcome: Staff reported Part 5 of the Rules was not being used.

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.*		
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.*	X	

Justification for this rating:

The service provided documentary evidence that much, but not all, had been done to remedy the deficits outlined in the Environmental Health Officer's inspection reports of 29 January 2009, 9 March 2009 and 12 October 2009.

Breach: 6(1)

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	
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
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

St. Peter's ward: Three residents attended Lime Grove activity centre. Remaining residents were on the ward at the time of inspection. There was no sign of any activities occurring on the ward. Some residents were wandering about. There was no programme of recreational activities displayed. There was a television on the ward.

St. Paul's ward: The white (activities) board was blank as the white board marker had run dry. Many residents were on the ward at the time of inspection. There was no sign that a programme of recreational activities was carried out. There was a television on the ward and a music system.

Breach: 9

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.*	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:

St. Peter's ward: Individual care plans, as defined in the Regulations, were in place.

St. Paul's ward: No resident had an individual care plan as defined in the Regulations. This ward also had no individual care plans for any resident last year. On the day of inspection, each resident had an individual care plan in their clinical file but all were completely blank. There had been no attempt by the General Adult team involved, to comply with the Inspectorate's recommendation from last year and with 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	
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		X

Justification for this rating:

St. Peter's ward: Three patients attended activities at Lime Grove centre. Staff reported that there was little for patients to do on the ward. Many patients could not leave the ward.

St. Paul's ward: Many residents remained on the ward during the day. The Inspectorate saw no indication that a programme of therapies was provided. No resident had an individual care plan.

Breach: 16 (1) (2)

Article 17: Children's Education

Children were not admitted to St. Finan's Hospital.

Article 18: Transfer of Residents

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.*		
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	

Justification for this rating:

A policy on Transfer of Residents was in place.

St. Peter's ward: One patient had been transferred from another approved centre. On examination of the clinical file, the Inspectorate was satisfied that this was based on clinical reasons and was in the best interests of the patient.

St. Paul's ward: No resident had been transferred.

Article 19 (1-2): General Health

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:

St. Peter's ward: Three clinical files were examined of patients who were in hospital for more than six months. All had physical reviews completed.

St. Paul's ward: Four clinical files of residents who had been in hospital for a period longer than six months were examined. Two residents had not received a full physical examination for fourteen months and sixteen months respectively contrary to the requirement of the Regulations. There was no documentation in either clinical file to indicate why these physical examinations had not taken place.

Breach: 19 (1) (b)

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

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:

St. Peter's ward: There was no information booklet on the ward. When this was requested by the Inspectorate, staff confirmed that none was available. Details of the residents' multidisciplinary team were not available or displayed. There was no written information for patients' treatment or medication of which the nursing staff was aware. There was no information about the Irish Advocacy Network or contact details displayed on the ward. Staff reported the advocate did not visit the ward.

St. Paul's ward: There was an information leaflet on the ward. Details of the residents' multidisciplinary team were not available or displayed. As in St. Peter's Ward, there was no written information for patients' treatment or medication of which the nursing staff was aware. There was no information about the Irish Advocacy Network or contact details displayed on the ward. Staff reported not being aware whether or not the advocate visited the ward.

The approved centre had a written operational policy.

Breach: 20(1)

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:

St. Peter's ward: The overcrowding issue identified in last year's report continued to be a problem with one resident sleeping permanently in a corridor alcove without privacy curtains.

Several beds did not have privacy curtains. Staff reported that ways of erecting these had been investigated, but were impossible to erect because of the high ceilings in the building.

Some residents had lockable wardrobes. Staff reported that other wardrobes could not be locked.

St. Paul's ward: Some privacy curtains were missing from a number of bed areas. The curtain and net curtain from one of the windows was missing.

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.*		
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:

This hospital was old and unfit for purpose. It continued to be of concern to the Inspectorate that 52 people lived within the walls of this stark, grey, sprawling building. It was reported that the heating bill for the approved centre for 2008 was €429,992 and in 2009 was €268,191. The Inspectorate had also requested the maintenance bill for the approved centre. It was reported that maintenance costs to the approved centre had not been apportioned separately but collectively under the Kerry Mental Health Service's budget and so was not available.

St. Peter's ward: The unit was large, allowing space for disturbed patients to pace. Residents had access to a small basic enclosed garden. The ward area had been recently painted so that it was bright and some new furniture had been provided in the last year. However in large areas of the walls, the paint was bubbling and there was some peeling. Staff reported it was hard to heat in winter and the windows were old and draughty. Extra portable electric radiators were used at times.

St. Paul's ward: The ward was clean. It was a large old ward in which residents were cared for and treated in cheerless surroundings.

Breach: 22

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
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	
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

The centre had a written operational policy that was compliant with this Article.

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 used for security purposes only.

Article 26: Staffing

WARD OR UNIT	STAFF TYPE	DAY	NIGHT
St. Peter's Ward	Nursing	4	3
	Housekeeping	1	0
St. Paul's Ward	Nursing	4	2
	Housekeeping	0	0
St. Martin's Ward	Nursing	3	2
	Housekeeping	1	0
O'Connor Ward East	Nursing	2	1
	Housekeeping	1	0
O'Connor Ward West	Nursing	2	1
	Housekeeping	1	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.*		
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:

Because of nursing staff retirements earlier in the year, temporary cover was provided for both St. Peter and St. Paul's wards by nursing staff that were not familiar with their respective wards. There was no occupational therapy service. Staff reported that there was access to both social work and psychology services but there was little evidence of multidisciplinary team involvement from the clinical files examined.

Breach: 26 (2)

Article 27: Maintenance of Records

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 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	
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
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

The Risk Management Policy was not compliant with all of the requirements set out in Article 32 of the Regulations.

The Inspectorate was handed ten different policies in relation to risk management by the approved centre. None of these were compliant with Article 32. There is a requirement under the Regulations (S.I. No.551 of 2006) for appropriate policies to be in place.

Breach: 29

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.*	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 32: Risk Management 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	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 Risk Management Policy did not comply with all of the requirements set out in this Article.

Breach: 32 (1) (2)

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: St. Paul's Ward: seclusion was not used.

St. Peter's Ward: No resident had been secluded this year to the date of inspection. The seclusion register was examined.

St. Martin's Ward: One resident had been secluded. The resident's clinical file was examined. The seclusion register was examined.

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:

The seclusion register had been completed satisfactorily. The documentation in the clinical file in relation to the seclusion of the resident was of a high standard. There was documentary evidence that the resident's next of kin had been informed. There was evidence from the clinical file that, following the seclusion episode, the resident had been afforded the opportunity to discuss the seclusion episode with a member of the multidisciplinary team. The centre had an up-to-date policy on seclusion that was reviewed annually. On the day of inspection, the seclusion room was being used as a bedroom while a number of bedrooms were being redecorated.

Breach: 8.4

ECT (DETAINED PATIENTS)

Use: ECT was not used in St. Finan's Hospital. No patient in the hospital was in receipt of a course of ECT.

MECHANICAL RESTRAINT

Use: St. Paul's ward, St Peter's ward: Staff reported that Mechanical Means of Bodily Restraint and Mechanical Means of Bodily Restraint under Part 5 of the Rules were not used.

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

PHYSICAL RESTRAINT

Use: St. Paul's Ward: Staff reported that Physical Restraint was not used.

St. Peter's ward: It was reported that Physical Restraint was not used. The Physical Restraint Clinical Practice Form book was examined and had not been used.

ADMISSION OF CHILDREN

Description: Children were not admitted to St. Finan's Hospital.

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

Description: St. Peter's ward, St Paul's ward: The incidents books were examined. All incidents were reported on the STARS web system. Deaths and a summary of all incidents were reported 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:

Risk Management Policy did not comply with all of the requirements as outlined in the Code of Practice.

Breach: 4

ECT FOR VOLUNTARY PATIENTS

Use: ECT was not used in St. Finan's Hospital. No patient in the hospital was in receipt of a course of ECT.

ADMISSION, TRANSFER AND DISCHARGE

Description: St. Paul's Ward: There had been no admissions in 2010. One patient had been discharged.

St. Peter's Ward: There had been no admissions this year to the date of inspection. One resident had been transferred.

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:

There were deficits with regard to staff information about ward systems because of the temporary cover necessitated by staff shortages. The training register was examined.

The policy on admissions had been due for review on 22 June 2006 and the policy on discharges had been due for review on 16 August 2007. There was no documentary evidence that these reviews had occurred. There was a written operational policy on transfers.

Up-to-date policies on Admission and Discharge were subsequently forwarded to the Inspectorate.

Breach: 9

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:

Staff reported there were very few admissions, discharges or transfers from St. Finan's Hospital up to the date of inspection.

The admission policy submitted to the Inspectorate was out of date for the past four years. An up-to-date Admission policy was subsequently forwarded to the Inspectorate.

No resident on St. Paul's ward had an individual care plan as defined in the Regulations.

Breach: 17

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 transfer policy referred to transfers to and from St. Peter's ward. One resident had been transferred from another approved centre. It was clear from the documentation in the clinical file that this was for clinical reasons. There was evidence of family involvement. The decision to transfer was clearly documented. There was evidence of assessment prior to transfer. It was clear that the resident's best interests had been taken account of.

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:

This was a long-stay hospital and few residents had been discharged. The discharge policy was out of date for almost three years. There was no evidence of peer advocate involvement. Staff reported being unaware of their attendance on the wards. There was no evidence of a key worker system in place on St. Paul's ward. An up-to-date discharge policy was subsequently forwarded to the Inspectorate.

Breach: 37, 39

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

Description: A number of residents had an intellectual disability and 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	COMPLIANCE INITIATED	NOT COMPLIANT
		X	

Justification for this rating:

St. Martin's ward: One resident with an intellectual disability and mental illness attended a day service run by Kerry Parents and Friends for activities each day. Staff reported that alternatives to admission to St. Finan's Hospital had been tried without success.

St. Paul's ward: It was reported there were no residents on the ward with intellectual disability and mental illness.

St. Peter's ward: It was reported that four residents had an intellectual disability and mental illness. All four residents had individual care plans. The service did not have policies in relation to this Code of Practice. Staff had not been provided with education and training to support the principles and guidance in this Code of Practice.

Breach: 5, 6

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

SECTION 60 – ADMINISTRATION OF MEDICINE

Description: Section 60 of the Mental Health Act (2001) applied.

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

Justification for this rating:

St. Paul's ward: Two clinical files examined were compliant with this section of the Act.

St. Peter's ward: Two clinical files examined were compliant with this section of the Act.

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

Description: Children were not admitted to St. Finan's Hospital so section 61 of the Mental Health Act (2001) did not apply.

SECTION THREE: OTHER ASPECTS OF THE APPROVED CENTRE

SERVICE USER INTERVIEWS

No resident requested to speak with the Inspectorate. Residents were greeted in all wards on the day of inspection.

MEDICATION

The prescription sheets were in Kardex format and some were untidy and difficult to follow. PRN (as required) medication was mixed in with regular medication and indications for PRN medication were not usually given. Discontinued medication was not always signed and some signatures were illegible.

MEDICATION LONG STAY

NUMBER OF PRESCRIPTIONS:	53
Number on benzodiazepines	34 (64%)
Number on more than one benzodiazepine	5 (9%)
Number on regular benzodiazepines	19 (36%)
Number on PRN benzodiazepines	24 (45%)
Number on hypnotics	20 (38%)
Number on Non benzodiazepine hypnotics	14 (26%)
Number on antipsychotic medication	47 (89%)
Number on high dose antipsychotic medication	10 (19%)
Number on more than one antipsychotic medication	23 (43%)
Number on PRN antipsychotic medication	21 (40%)
Number on antidepressant medication	17 (32%)

Number on more than one antidepressant	**2 (4%)**
Number on antiepileptic medication	**20 (38%)**
Number on Lithium	**5 (9%)**

OVERALL CONCLUSIONS

St. Finan's Hospital, Killarney, was not suitable for the care and treatment of residents. Acute admissions no longer went to this approved centre, nevertheless, on the day of inspection 52 people lived within the walls of this stark, grey, sprawling building. Kerry Mental Health Services had in their possession, for some years now, plans for new units to replace St. Finan's Hospital. These plans included the building of a 25-bed continuing care and challenging behaviour unit for older persons with mental health problems, a 15-bed intensive care rehabilitation unit, and a 10-bed community residence for remaining residents. The Inspectorate had been informed of these plans, and, for the past three years during inspections, had been reminded by the senior management team of the existence of these plans. It can only be described as frustrating that there has been no advance, in any shape or form, with any of these developments due to the lack of capital funding. Inside this building, there are wards where people are sleeping in rows of beds in long dormitories with no privacy, inadequate washing and toilet facilities and stark surroundings. The space was so cramped on St. Peter's ward that the residents' lockers had to be situated away from the bed space in a different location on the ward. The Inspectorate was also informed that the hospital was difficult to heat in winter. Staff were frank, open and honest about their feelings when speaking to the Inspectorate about the failure of the commencement of the proposed future development. They felt that they, and the residents, were voices unheard. Staff at all levels presented as frustrated, disenchanted and upset at the living conditions of the residents in their care and of the working conditions they had to face each day.

RECOMMENDATIONS 2010

1. The approved centre was not fit for purpose and should be closed as soon as possible.

2. The approved centre must have a Risk Management policy that was compliant with the Regulations.

3. All policies should be reviewed at least three yearly.

4. Policies in relation to the Rules and Codes of Practice should be reviewed on an annual basis.

5. The system for providing information to residents must improve.

6. Therapeutic services and programmes must be based on the individual needs of all residents and must be delivered in accordance with their individual care plans.

7. The recreational needs of residents must be attended to.

8. The service should have regular visits from a representative of the Irish Advocacy Network.

9. Separate maintenance and heating costs must be maintained for St. Finan's Hospital.