Report of the Inspector of Mental Health Services 2008

HSE AREA	HSE Dublin Mid Leinster
CATCHMENT	Dublin West/South West
MENTAL HEALTH SERVICE	Dublin West/South West
APPROVED CENTRE	St Loman's Hospital, Palmerstown
NUMBER OF UNITS OR WARDS	1
UNITS OR WARDS INSPECTED	Laura Unit
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	22
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	2 September 2008

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

INTRODUCTION

In 2008, there was a focus on continuous quality improvement across the Mental Health Service. The Inspectorate was keen to highlight improvements and initiatives carried out in the past year and track progress on the implementation of recommendations made in 2007. Information was gathered from service user questionnaires, staff interviews and photographic evidence collected on the day of the inspection.

DESCRIPTION

Laura Unit was a stand-alone rehabilitation unit on the grounds of the old St Loman's Hospital, Palmerstown.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Laura Unit	22	12	Rehabilitation

On the day of inspection the unit had a complement of 22 beds with 12 residents residing in the unit. This number was considerably less than on previous inspections and the service should consider closing some of the vacant beds. The unit had an open door policy and all residents were voluntary.

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. The multidisciplinary team should be fully staffed with core disciplines included.

Outcome: The MDT was not fully staffed with all core disciplines. There was no clinical psychologist and only 0.3 whole-time-equivalent (WTE) principal social worker.

2. Following the introduction of individual multidisciplinary team (MDT) care plans, the service should look at developing a single composite set of notes for each resident.

Outcome: There was one composite set of clinical notes for each resident. The files were in good order and well organised.

3. The developing multidisciplinary team should set aside time on a regular basis to focus on team business, development and functioning.

Outcome: The members of the team available meet on a weekly basis.

4. Consideration should be given to the provision of a private space for visits.

Outcome: A room was now available for visits.

5. Residents should have appropriate access to physiotherapy and dietetic services.

Outcome: The service reported that since last year's inspection, access to dieticians had improved and access to speech and language therapy had been provided. The service continued to experience difficulty accessing physiotherapy services for residents. The Inspectorate was informed that access to physiotherapy may have to be sorted out at local health manager level and this was complicated by the fact that the approved centre was the responsibility of two different local health offices.

MDT CARE PLANS 2008

MDT care plans were in place for each resident. There was evidence of formal assessments by team members and regular reviews. The resident had a copy of their care plan if they wished and attended the team meeting. Unmet needs were recorded. There was a keyworker system in place.

GOOD PRACTICE DEVELOPMENTS 2008

- Training for nursing staff dealing with challenging behaviour had been planned and was due to commence.
- Solution-focused therapy was in place on the unit.
- An audit had been completed on care plans.
- Health and safety training had been implemented and a committee established within the service.
- MDT assessments were completed on all referrals to the service.

SERVICE USER INTERVIEWS

A number of residents spoke informally with the Inspectorate but no one requested a specific meeting. One of the residents commented that the unit was spacious, there was a lot to do during the day and staff were very helpful.

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

1. The rehabilitation team should be made up of a full multidisciplinary team.

2. The admission policy should reflect current practice by including a statement that all referrals must have an MDT assessment prior to admission or transfer.

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

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 2 SEPTEMBER 2008

Article 6 (1-2) Food Safety

At the time of the inspection, the report of the environmental health officer had just been received by the service. This highlighted a number of issues to be addressed.

Breach: Article 6

Compliant: No

Article 12 (1-4): Communication

The approved centre had a communication policy, implemented in August 2008 and due for review in March 2009.

Compliant: Yes

Article 15: Individual Care Plan

Individual care plans had been introduced for all residents. Multidisciplinary team meetings were held weekly and each resident's care plan was reviewed in detail at least every three weeks. The team had introduced multidisciplinary assessments prior to admission.

Compliant: Yes

Article 16: Therapeutic Services and Programmes

A range of therapeutic activities were available on the unit provided by the occupational therapist and activity area staff. The service reported that since last year's inspection, access to dieticians had improved and access to speech and language therapy had been provided. The service continued to experience difficulty accessing physiotherapy services for residents. The Inspectorate was informed that access to physiotherapy may have to be sorted out at local health manager level and a complicating factor was that the approved centre was the responsibility of two different local health offices. The service subsequently reported that this issue had been taken up by the Local Health Manager.

Breach: Access to physiotherapy was not sufficient to meet the needs of the residents [Article 16 (2)].

Compliant: No

Article 17: Children's Education

The unit did not admit children.

Compliant: Not applicable

Article 18: Transfer of Residents

Policies and procedures were implemented on 8 September 2005, reviewed on 26 March 2007, and had a future review date of 2009.

Compliant: Yes

Article 19 (1-2): General Health

Policies and procedures relating to physical health were reviewed in January 2008 with a future review date of March 2009.

Compliant: Yes

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

The unit had developed an information booklet for residents. The residents attended the MDT meetings and were familiar with the team members as a result of attending this forum.

Compliant: Yes

Article 21: Privacy

All the beds in the shared rooms had curtains around them. All single rooms had en suite facilities. Segregated bathroom and bedroom facilities were available.

Compliant: Yes

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

Policies and procedures for medication management were implemented in November 2006, reviewed in January 2008, and due for future review in March 2009. A pharmacist attended every Tuesday.

Compliant: Yes

Article 25: Use of Closed Circuit Television (CCTV)

CCTV was not used in the unit. CCTV had recently been installed for security purposes to monitor the perimeter of the buildings and grounds and was not used for the purpose of observing residents.

Compliant: Yes

Article 26: Staffing

The rehabilitation team provided care and treatment to the residents in the unit. It had a consultant psychiatrist, a NCHD, an assistant director of nursing, two full-time occupational therapists, a sessional principal social worker, one recreational staff and two care staff. The unit was staffed by psychiatric nurses, and care staff, with part-time input from the occupational therapists and recreational staff. A clinical nurse manager was in charge of the unit. The team had no clinical psychology and only 0.3 WTE social work.

The following table provides a summary of the current unit staffing levels.

STAFF TYPE	DAY	NIGHT
RPN	5 (including 1 CMN2 0800h to 1700h Mon-Fri)	2
Care staff	2	0
Household staff	2	–

Breach: Clinical psychologists were not available to the approved centre and access to physiotherapy was not provided based on the needs of the residents [Article 26 (2)].

Compliant: No

Article 30: Mental Health Tribunals

The approved centre did not admit detained patients

Compliant: Not applicable

Article 32: Risk Management Procedures

The approved centre had a draft risk management policy.

Breach: The approved centre did not have an operational risk management policy [Article 32 (1)].

Compliant: No

Article 33: Insurance

An up-to-date copy of the insurance details was made available to the Inspectorate.

Compliant: Yes

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

SECLUSION

It was reported to the Inspectorate that seclusion was not used and the service had a written statement to this effect.

Compliant: Not applicable

ECT

It was reported to the Inspectorate that ECT was not administered on this unit and the service had a written statement confirming this.

Compliant: Not applicable

MECHANICAL RESTRAINT

The Inspectorate was informed that mechanical restraint was not used and the service had a written statement confirming this.

Compliant: Not applicable

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

PHYSICAL RESTRAINT

The Inspectorate was informed that physical restraint was seldom used on the unit. There had been no episodes of physical restraint on the unit since the last inspection. A policy was in place should physical restraint be required in an emergency situation and the clinical practice forms were available. Records of staff training in relation to physical restraint were provided to the Inspectorate.

Compliant: Yes

ADMISSION OF CHILDREN

Children were not admitted to this unit.

Compliant: Not applicable

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Code of Practice for the Notification of Deaths and Incident Reporting.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Notification of deaths**	Compliant
3	**Incident reporting**	Compliant
4	**Clinical governance**	Compliant

Compliant: Yes

ECT FOR VOLUNTARY PATIENTS

ECT was not used in this service.

Compliant: Not applicable

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

This was not applicable as the unit had no detained patients.

Compliant: Not applicable