Report of the Inspector of Mental Health Services 2010

EXECUTIVE CATCHMENT AREA	Carlow/Kilkenny and South Tipperary
HSE AREA	South
CATCHMENT AREA	South Tipperary
MENTAL HEALTH SERVICE	South Tipperary
APPROVED CENTRE	St. Michael's Unit, South Tipperary General Hospital
NUMBER OF WARDS	2
NAMES OF UNITS OR WARDS INSPECTED	Male Ward Female Ward
TOTAL NUMBER OF BEDS	49
CONDITIONS ATTACHED TO REGISTRATION	Yes
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	19 August 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. Michael's Unit was a locked, stand-alone unit in the grounds of South Tipperary General Hospital. On the day of inspection the glass entrance was manned by a security officer who vetted visitors according to a list supplied by nursing staff. The building was dated, and the standard of decor poor and inadequately maintained. There was no garden for residents and the quality of air in the building was stuffy. This was particularly so in the small locked high observation areas to which people could be confined when first admitted. Fans in the smoking rooms in these areas did not adequately clear the air which smelled of smoke. Staff reported that the approved centre generally operated at 114% capacity. On the day of inspection there were 52 residents, five residents were on leave and there were five detained patients. Four children had been admitted since January 2010, one of whom had been a Section 25 involuntary admission.

The conditions attached to the registration of the approved centre required full compliance with Articles 15, 16, 18, 20, 21, 22, & 26 of the Mental Health Act 2001 (Approved Centre) Regulations 2006.

DETAILS OF WARDS IN THE APPROVED CENTRE

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Female Ward	24	28 (four female residents on leave)	3 General Adult Teams 1 In-patient Team North Tipperary
Male Ward	25	24 (one male resident on leave)	Psychiatry of Old Age Rehabilitation Team

QUALITY INITIATIVES

- An occupational therapist had been appointed during the year to one of the sector teams and provided sessional therapeutic intervention in St. Michael's Unit
- Security staff had been employed to monitor the entrance to the approved centre. Staff reported that this had resulted in a more therapeutic ward environment for residents and had helped reduce the likelihood of illegal substances being brought onto the approved centre.

- A Primary Nurse system had been introduced. All residents were allocated a primary nurse according to the treating team on a daily basis. Information on this was placed on the ward notice board.
- A theatre nurse from the South Tipperary General Hospital assisted in the administration of ECT.
- An integrated clinical file system had been introduced.
- A policy decision had been taken to replace clinical files once they reached a size of 80 mm thus making them more manageable.
- A social worker provided a fortnightly talk to residents about their welfare entitlements.
- A case conferencing system involving all significant stakeholders, including the resident and family if applicable, had been introduced for longer term residents.
- A monthly Homeless Action Meeting had been established with social work, nursing staff and relevant local voluntary and statutory agencies.
- Risk management and clinical incident review was now, firstly reviewed at ward level to benefit learning and then went to the wider multidisciplinary risk management review meetings where recommendations were made.
- A multidisciplinary clinical governance committee had been established which also included the peer advocate.

PROGRESS ON RECOMMENDATIONS IN THE 2009 APPROVED CENTRE REPORT

1. There should be an occupational therapist in St. Michael's Unit.

   Outcome: An occupational therapist had been appointed to one of the sector teams and provided sessional input to St. Michael's Unit.

2. All individual care plans should be completed in full.

   Outcome: This had been achieved.

3. Therapeutic services and programmes should be linked to the individual care plans.

   Outcome: Therapeutic services and programmes were linked to individual care plans.

4. A senior nurse manager should be based at the approved centre for the full 24-hour period.

   Outcome: An Assistant Director of Nursing was based during office hours in St. Michael's Unit. A Clinical Nurse Manager 3 (CNM3) was on duty at night in St. Michael's Unit and responded to issues in St. Luke's Hospital.

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	
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.*		

St. Michael's Unit had a single sitting room, with eight chairs to cater for the 52 residents. This room housed a television set and an altar stand for the weekly scheduled Roman Catholic Mass. A separate small room contained a few books and board games, this was locked and staff informed the Inspectorate that this was opened selectively if a resident required a quiet space or to meet with visitors. There was an exercise bike in the activity room, but no general gym area. There was an unattractive yard area where residents smoked. There was also a small unkempt outdoor patio area with two mosaic tables and chairs, which were in poor repair. There was no meaningful provision of recreational activities for residents, several of whom had been in the approved centre for upwards of one year.

The high observation areas, located at either end of the male and female wards, had no access to outdoor space, and had no seating area other than a smoking room. Staff informed the Inspectorate that residents might be accommodated in this area for up to three weeks, often in the initial stage of admission. The area was confined and small and did not provide the opportunity to walk around or to be out of earshot of others and was not conducive to mental well-being.

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.*		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:

A number of clinical files were examined and all had individual care plans which were completed on a regular basis and in accordance with the Regulations. Residents had signed their individual care plans in all cases.

Article 16: Therapeutic Services and Programmes

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:

An activity programme and therapeutic groups were provided and co-ordinated by a dedicated activity nurse. The range and number of options was excellent and reflected identified needs of residents as detailed in individual clinical files. There was a single activity room where groups and activities took place and this room impressed as a hub of activity. The addition of a sessional occupational therapist meant that therapeutic groups could be co-facilitated and there was good interdisciplinary communication and collaboration. Programmes reflected evidence based practice. The occupational therapist also provided functional assessment and individual intervention essential to progressing residents towards discharge and community living. An art teacher provided a weekly class. A social worker provided a fortnightly session on welfare entitlements. The clinical psychology post attached to the Clonmel East team had become vacant and no replacement appointed. One resident expressed concern over the discontinuation of psychotherapy. There were three clinical psychologists attached to sector teams who provided individual therapy.

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:

Educational provision was made as appropriate when a child was admitted. There were no children in the approved centre on the day of inspection.

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 policies in place in relation to the transfer of residents and all relevant clinical information accompanied the resident on transfer. It was evident that residents had been transferred to another approved centre for the purpose of bed management and not for individual clinical need as stipulated in individual clinical files.

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:

Policies and procedures were in place. Two clinical files of individuals resident in the approved centre for longer than six months were inspected and physical examinations had been completed and recorded appropriately. The approved centre maintained a log to flag upcoming six-monthly general health examinations.

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 ORCHID patient information system was available on computer for residents. The activities nurse and occupational therapist kept a library of mental health information and provided this on a tailored individual basis to residents. A housekeeping booklet was given to residents on admission. A number of information leaflets were available on various aspects of the service. Notice boards had information on the Irish Advocacy Network, ward activities and the Health Service Executive complaints procedure. There were relevant policies and procedures in place.

Article 21: Privacy

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:

Shared bed areas had privacy curtains. Windows were frosted. A policy was available.

Article 22: Premises

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:

While the ward areas were clean and comfortable, the general standard of the premises was far below what was expected of a healthcare facility. The building was poorly maintained. Paint was peeling in several areas of the building. Staff reported that requests had been submitted to hospital maintenance some time previously and they were awaiting a response. Some shower and toilet areas were in need of refurbishment owing to stained and cracked tiles and stained floor covering. Several lavatories were malodorous. There was little sense of fresh air circulating in the approved centre and the unit felt stuffy. This was particularly so in the high observation units which were locked. Residents were confined whilst in the high observation area as there was no access to an exterior garden. Other residents had access to an outside space. A television room had space for just eight chairs, although there were 52 residents. The area needed to be painted. There was evidence of dampness in the ceiling of the seclusion room. Showers were not wheelchair accessible.

Breach: 22 (1) (a) (b) (c), (2), (3)

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	
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.*		

The fire safety officer's report of 2009 recommended the upgrading of the fire-doors across the corridors. This remained undone at the time of inspection. The approved centre failed to respond to a subsequent request to provide evidence that the upgrading of the relevant fire doors had been completed.

Breach: 24

Article 25: Use of Closed Circuit Television (CCTV)

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 26: Staffing

WARD OR UNIT	STAFF TYPE	DAY	NIGHT
St. Michael's Unit	Nursing	1 CNM2 1 CNM1	1 CNM3
		10 Staff Nurses 1 Activities Nurse	6 Staff Nurses
	Housekeeping	5	1
	Allied Health Professionals on sector teams: Occupational therapy Social work Clinical psychology	 3 3.8 3	

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:

An appropriately qualified staff member was on duty and in charge of the approved centre at all times. An occupational therapist had been employed in March 2010. A psychologist, who had provided psychotherapy, had left the service and had not been replaced. A service user interviewed expressed concern that this psychotherapy service had been helpful to them and they missed it. Policies and procedures were in place. None of the sector teams had a sufficient complement of multidisciplinary professionals.

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:

The clinical files were in good condition and information was well organised and easy to retrieve. A policy had been adopted to replace files deeper than 80mm. Clinical files were colour coded, up-to-date and all signatories clearly identified. Reports on Food Safety, and Health and Safety were available to the Inspectorate. Relevant policies were in place.

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.*	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.*	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 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: Seclusion was used in the approved centre. No patient was being secluded on the day of inspection. At the time of inspection there had been ten episodes of seclusion involving seven residents on the male ward in 2010. There had been 14 episodes of seclusion involving ten residents on the female ward in 2010.

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:

Staff reported that the seclusion rooms were used as bedrooms owing to overcapacity in admissions. Seclusion rooms must not be used as bedrooms.

Both seclusions registers were completed in accordance with the Rules. Families were informed as a matter of course and details about the seclusion episode were entered in the individual clinical files. The approved centre had developed an excellent report template to record the debriefing provided to a resident after an episode of seclusion.

Breach: 8.4

ECT (DETAINED PATIENTS)

Use: No detained resident was in receipt of ECT on the day of inspection.

MECHANICAL RESTRAINT

Use: Mechanical Restraint was not used in the approved centre.

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

PHYSICAL RESTRAINT

Use: At the time of inspection there had been 27 incidents of physical restraint on the male ward and 28 incidents on the female ward in 2010. Both sets of Clinical Practice Form books were in order.

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:

The Clinical Practice Form book was examined and found to be in order. The clinical file of one resident who had been physically restrained was inspected and was in order. The debriefing tool was completed, signed and dated. A policy was in place.

The staff training log indicated that the majority of staff did not have up-dated training in break away techniques or in control and restraint techniques.

Breach: 10.1

ADMISSION OF CHILDREN

Description: At the time of inspection, four children had been admitted to the approved centre in 2010. Of these, one had been involuntary. There was no child resident 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 clinical file of a child admitted involuntarily was examined and found to be in order.

The approved centre had policies in place in accordance with the Code of Practice on the Admission of Children.

The approved centre was not suitable for the admission of children.

Breach: 2.5

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

Description: The approved centre reported deaths and incidents 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:

The approved centre had policies and procedures in place. Incidents were reviewed regularly by clinical and administrative management with a proactive approach.

ECT FOR VOLUNTARY PATIENTS

Description: There was one voluntary resident receiving ECT at the time of inspection.

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:

The Clinical Practice Forms for four residents who had received ECT were examined and found to be in order. There was one resident who was undergoing a course of ECT and the clinical file of this voluntary resident was examined and in order.

ADMISSION, TRANSFER AND DISCHARGE

Part 2 Enabling Good Practice through Effective Governance

Description: The approved centre had policies in place in relation to admission, transfer and discharge.

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's risk management was robust. Staff information and training provided meant that staff had a clear understanding of their roles.

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:

A number of clinical files were examined and there was evidence of a pre-admission process, there was evidence of collaboration with community mental health services and family. The approved centre used a number of appropriate evidence based tools in the admission assessment. Residents had a primary nurse and were involved in their own individual care planning.

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:

There was evidence that two residents had been transferred to another approved centre for the purposes of relieving bed shortages in St. Michael's Hospital. This was contrary to the Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre. The transfer of a resident should only take place when it is considered to be in the best interests of the resident. The approved centre's own policy on transfer of patients had not been adhered to.

Breach: 25.1(a)

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:

There was evidence of pre-discharge planning and collaboration with community mental health services and both voluntary and statutory agencies. Family were involved as appropriate and there was evidence of planned follow up.

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

Description: There was one resident with an intellectual disability and mental illness on the day of inspection.

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 had policies and protocols in relation to the Code of Practice “Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities”. Staff had not received training in working with individuals with an intellectual disability and mental illness.

There was an individual care plan in place.

Breach: 6

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

SECTION 60 – ADMINISTRATION OF MEDICINE

Description: Section 60 applied to one resident and consent was recorded in the clinical file inspected.

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

Justification for this rating:

Consent was recorded. The approved centre had a procedure for flagging in the individual clinical files any upcoming Section 60 consent which might be required.

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

Description: Up to the date of inspection in 2010, one child had been admitted under Section 25. This child remained in the approved centre for a period less than three months and Section 61 did not apply.

SECTION THREE: OTHER ASPECTS OF THE APPROVED CENTRE

SERVICE USER INTERVIEWS

The approved centre had regular community meetings which had led to the nomination of a resident representative. The Inspectorate met with the representative who reported that many residents were very concerned about the pending closure of St. Michael's Unit and the moving of admissions to Kilkenny. Their concerns were about the distance imposed on families and what local community service provision might be available in the future.

MEDICATION

The medication sheets were in booklet format and the prescriptions were legible. However the vast majority of signatures were illegible. There was a signature log for identification. Medical council registration number was recorded. PRN (as required) medication was separate from regular and depot medication and was easy to follow. There were no indications for PRN medication documented.

The prescription of benzodiazepines was extraordinarily high. Eighty one per cent of residents were prescribed benzodiazepines. Over two thirds of residents were on regular benzodiazepines and 45% of residents were prescribed more than one benzodiazepine. Likewise nearly three quarters (73%) were prescribed night sedation. Polypharmacy was common with over one third of resident's prescribed more than one antipsychotic medication.

MEDICATION ACUTE

NUMBER OF PRESCRIPTIONS:	49
Number on benzodiazepines	40 (81%)
Number on more than one benzodiazepine	22 (45%)
Number on regular benzodiazepines	33 (67%)
Number on PRN benzodiazepines	18 (37%)
Number on hypnotics	36 (73%)
Number on Non benzodiazepine hypnotics	16 (32%)
Number on antipsychotic medication	43 (88%)
Number on high dose antipsychotic medication	7 (14%)
Number on more than one antipsychotic medication	17 (35%)

Number on PRN antipsychotic medication	**10 (20%)**
Number on antidepressant medication	**30 (61%)**
Number on more than one antidepressant	**10 (20%)**
Number on antiepileptic medication	**20 (41%)**
Number on Lithium	**6 (12%)**

OVERALL CONCLUSION

St. Michael's Unit had been consistently running well over bed capacity for a number of years. Staff reported that the approved centre usually ran at 114% of capacity and that the seclusion rooms had been used as bedrooms during 2010 owing to an overcapacity in admissions. The approved centre appeared to balance bed numbers through placing a number of residents on leave. There was a need for active review of the care pathways and bed management systems operating in the catchment area, including the use of leave. Several residents had been in the approved centre for upwards of one year. Five residents were out on leave, including one person on extended leave. There was a protracted delay in discharging one resident to a residence for those with an intellectual disability and mental illness.

Residents had been transferred to another approved centre for the purpose of alleviating bed shortages and this was in breach of the conditions attached to the Registration of the approved centre.

The primary nurse system appeared to be working well and communication between staff and residents was good. The approved centre had continued its practice of incorporating the Sainsbury Risk Assessment Tool and the Camberwell Assessment of Need into its screening process. An inspection of files indicated that this informed multidisciplinary team care planning in a meaningful way. Standards had been maintained in individual care planning. There was excellent provision of therapeutic services and programmes by the activities nurse and the occupational therapist.

The prescription of benzodiazepines and night sedation was very high, although the standard of prescriptions was reasonably good.

Mandatory staff training in many areas was poor. Less than one in ten staff had had fire drill training within the last year.

The projected timeline for the closure of St. Michael's Unit was March 2011 and at that time future admissions would be to the Department of Psychiatry, St. Luke's Hospital, Kilkenny. Staff reported to the Inspectorate that discussions were at an initial stage about the provision and development of community based services such as home based teams and crisis beds. Catchment area teams remained under resourced with health and social care professionals.

RECOMMENDATIONS 2010

1. The approved centre must not transfer residents in order to alleviate bed shortages.

2. The seclusion rooms must not be used as bedrooms.

3. The approved centre should make adequate provision for recreational activities for residents.

4. The outdoor areas should be upgraded and rendered hospitable for residents.

5. Community mental health teams should be adequately resourced with health and social care professionals.

6. Ongoing maintenance and painting should be done.

7. A review of benzodiazepine prescribing must take place as soon as possible.

8. Mandatory staff training must be up-dated in accordance with local policy.