These reports were prepared on the basis of information and documentation obtained from mental health service providers and users during the inspection process 2007. The draft individual reports were sent to the relevant health service provider. Where appropriate, the comments received back were incorporated in the final versions of the reports.
## CONTENTS

<table>
<thead>
<tr>
<th>INDEPENDENT HOSPITALS</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bloomfield Wing</td>
<td>5</td>
</tr>
<tr>
<td>Hampstead Private Hospital</td>
<td>6</td>
</tr>
<tr>
<td>Highfield Private Hospital</td>
<td>14</td>
</tr>
<tr>
<td>Kylemore Clinic</td>
<td>21</td>
</tr>
<tr>
<td>Palmerstown View, Stewart’s Hospital</td>
<td>29</td>
</tr>
<tr>
<td>St. Edmundsbury Hospital</td>
<td>36</td>
</tr>
<tr>
<td>St. John of God Hospital</td>
<td>44</td>
</tr>
<tr>
<td>St. Patrick’s Hospital</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>59</td>
</tr>
</tbody>
</table>
BLOOMFIELD WING

<table>
<thead>
<tr>
<th>APPROVED CENTRE</th>
<th>BLOOMFIELD WING</th>
</tr>
</thead>
<tbody>
<tr>
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<td>BLOOMFIELD WING</td>
</tr>
<tr>
<td>DATE OF INSPECTION</td>
<td>15 MARCH 2007</td>
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<tr>
<td>NUMBER OF BEDS</td>
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INTRODUCTION

Bloomfield Wing was an approved centre under the Mental Health Act 2001 when the inspection was carried out. The purpose of this announced inspection was to comment on the quality of care and treatment given to residents in receipt of mental health services and determine the degree and extent of compliance by the approved centre with the Regulations, Codes of Practice and Rules for Treatment (Sections 50 to 55 and 66, Mental Health Act 2001). The Inspectorate also followed up recommendations from the 2006 report, on multidisciplinary team (MDT) functioning and care planning, and spoke to residents where requested.

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

1.1 DESCRIPTION

Bloomfield Wing, Bloomfield Care Centre, was situated in Rathfarnham, Dublin, and was managed under the guidance of the Quaker community in Ireland. It was located on the first floor of a two-storey building and provided care to frail and elderly residents and those with dementia and related conditions. On the day of the inspection, there were 12 male and 23 female residents whose ages ranged from 49 to 96 years. Of these, 33 residents were voluntary and two residents were Wards of Court. There had been no involuntary admissions since the introduction of Part 2 of the Mental Health Act 2001 in November 2007. The unit operated at tertiary level, accepting referrals from community-based sector teams.

The unit was locked for reasons of resident safety, to prevent wandering.

1.2 RECOMMENDATIONS ARISING FROM THE 2006 REPORT

1. There must be an individual multidisciplinary team care plan and treatment plan for each resident.

**Outcome:** There had been no progress on this recommendation. The unit did not have a multidisciplinary team and separate nursing and medical care plans and notes were maintained.

2. Consideration must be given to incorporate the nursing notes onto the computerised system.

**Outcome:** There had been no progress on this recommendation.

3. Each resident must have an individual written financial account at ward level and a financial policy must be developed.

**Outcome:** Residents each had a book that recorded their personal allowance. Receipts for items bought were kept in the book. There was no record of the resident’s account balance in the book. The Inspectorate was unable to ascertain the criteria for calculating the amount of personal allowance available for individual residents. It was also unclear what arrangements were in place to ensure that residents received the balance of their pensions following deduction of charges for in-patient services, or what arrangements were in place to ensure that this money was credited to their accounts. It was reported that Bloomfield management had written to the HSE to seek direction regarding the management of personal allowances for HSE residents but had not yet received a reply.

4. There must be a set ongoing review of the activity programmes to ensure that they are meaningful to the residents.
registered medical officers, who provided medical care to the residents on a sessional basis. Psychiatric reviews were undertaken by consultant psychiatrists and NCHDs from the resident’s catchment service when required. Apart from the Director of Nursing, there were no registered psychiatric nurses on the unit. It was reported that informal meetings were held on the unit between medical and nursing staff regarding the care of residents.

1.4 MULTIDISCIPLINARY TEAM CARE PLANS

The unit did not have integrated MDT care plans. Each resident had a nursing care plan and these were reviewed regularly.

1.5 THERAPEUTIC ACTIVITIES

While a number of therapeutic activities were available, they were not provided on the basis of needs assessment and were not linked to MDT care plans.

1.6 ENVIRONMENT AND FACILITIES

The buildings and furnishings were of a high standard. The premises were new and purpose built. Maintenance was reported to be excellent and repairs were carried out quickly. Specialist equipment was available following assessment of needs. The premises were fully accessible. The outside gardens and grounds were well maintained.

1.7 INTERVIEWS WITH RESIDENTS

None of the residents asked to meet formally with the Inspectorate, however a number of residents spoke to the Inspectorate during the inspection of the environment.
1.8 GOOD PRACTICE DEVELOPMENTS

1. The range of activities available to residents had been expanded since the last inspection.

2. The hospital was recruiting for the post of coordinator of activities. It was planned that this appointee would have responsibility for the coordination, evaluation and further development of social and recreational activities for residents.

3. The unit had engaged the services of a dietician on a pilot basis. This had resulted in a number of recommendations, including increasing the variety of each resident’s diet and improving the visual presentation of food. The hospital had committed to accessing the services of the dietician as required and it was planning to survey residents and relatives in relation to food preferences.

4. Some policies had been standardised.

5. The unit facilitated groups of occupational therapy students from Trinity College Dublin for half a day each week.

6. The proposed capital development programme for Bloomfield Care Centre was approved by the HSE Capital Appraisal Group in December 2006. This envisaged an additional 77 beds, a psychiatry of later life team, and facilities to provide a continuum of care for the catchment population.

1.9 2007 RECOMMENDATIONS ON THE QUALITY OF CARE AND TREATMENT – MENTAL HEALTH ACT 2001, SECTION 51(1)(b)(i)

1. The unit should have individual care plans as defined in the Regulations and one composite set of notes for each resident.

2. The residents should have regular review by the multidisciplinary team.

3. Therapeutic/recreational activities should be derived from the individual care plan.

4. The unit should have a policy in relation to residents’ finances and more stringent protocols for dealing with residents’ money. The service should have a system to ensure that residents receive the balance of their pensions (i.e. the amounts remaining from their pensions following the deduction of charges for in-patient services) or that these monies are credited to their accounts.

5. Nursing and care staff should have regular in-service training on the management of residents with challenging behaviour.

6. The unit should continue to develop links with relevant advocacy agencies.

PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE ON 15 MARCH 2007

2.1 EVIDENCE OF COMPLIANCE WITH REGULATIONS 2006 – MENTAL HEALTH ACT 2001, SECTION 52(d)

This part of the report was completed using a number of evidence bases: a self-assessment report completed by the service and submitted to the MHC Quality and Standards Division prior to the inspection date, interviews with the CNM2, the CEO, one of the medical officers and the Director of Nursing, and a paper review of all relevant documents on the unit and in the hospital. Feedback was given by the Inspectorate to the senior management team following the inspection.
Article 4: Identification of Residents

Nursing staff were consistent on the unit and the resident population changed little over time, so the residents were well known and easily identified by staff. In addition, photos of residents were attached to nursing care plans and medication cards. A new nursing care plan was being used on a pilot basis for new admissions. There had only been one admission since its introduction and this new care plan did not include a photo.

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Article 5: Food and Nutrition

There was a water dispenser attached to the mains water supply in the kitchenette on the unit and in the cafeteria. These areas were accessible to residents who were mobile. Nursing and care staff brought water to other residents as requested. The meal times were organised to facilitate residents and were well spaced throughout the day. Three residents who were mobile had access to the kitchenette for snacks and meals as required. Food preparation was contracted to a commercial company. A dietician had provided advice in relation to nutrition and had provided a report of dietary requirements for the residents. On the day of the inspection, there was only one main course available to residents.

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<th>COMPLIANT</th>
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Article 6 (1-2): Food Safety

This was not inspected on the day.

Article 7: Clothing

The Inspectorate examined some of the residents’ money books. It was reported by staff that when an individual resident did not have sufficient money available for new clothes, the hospital provided funds or relatives had been asked to bring in required items. Staff informed the Inspectorate that all residents were encouraged to wear day clothes during the day. None of the residents in the day rooms were observed to be wearing night clothes during the inspection visit.

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<th>COMPLIANT</th>
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Article 8: Residents’ Personal Property and Possessions

The unit had a policy for property and possessions of residents that was being revised. The Inspectorate was given a copy of the draft revision. A list of personal property was stored at the nurses’ station in a property book, separate to the individual’s care plan. Residents had a personal locker and wardrobe in their rooms for the storage of clothes and personal belongings. TV sets, radios, photographs and other personal items were observed in bedrooms. Residents had personal bags for sending clothes to the laundry to prevent them being mixed up. Residents had individual purses for keeping their money.

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<th>COMPLIANT</th>
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Article 9: Recreational Activities

A range of recreational activities were provided both on the unit and in the local community, including bingo, sing-songs, pottery, art, music and film shows and bus outings. The garden was also accessible to residents. The range of activities had been expanded since the last inspection visit.

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Article 10: Religion

A number of religious services were available to the residents, including weekly Roman Catholic and Jewish services and Quaker prayer meetings. The local Roman Catholic parish chaplain also visited regularly.

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<th>COMPLIANT</th>
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<th>NO</th>
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</table>
Article 11 (1–6): Visits
A number of areas were used for visiting on the unit and in the grounds of the hospital, including the bedrooms, day rooms, kitchenette, downstairs cafeteria, and garden. These areas facilitated visiting by children and privacy during visits. Staff reported that visitors were encouraged to take residents off the premises where possible. Visiting times were between 0900h and 2100h. There was a policy on visiting that provided for restriction of visits when necessary. Health and safety issues were identified in the visiting policy and in the hospital’s health and safety statement. There was a logbook at the main reception for visitors to complete. Facilities for hand washing were in place at the entry and exit points in the unit. The door into the unit was locked to prevent residents wandering and to keep out unwanted intruders. There was an enclosed outdoor space for residents.

Article 12 (1–4): Communication
Outgoing mail was collected by unit staff and brought to the main administrative office from where it was posted. Incoming mail was given directly to residents. There was a cordless phone handset, available to all residents to make and receive phone calls, and it could be used in the resident’s bedroom for privacy. One resident had a phone in the bedroom. The unit did not have a policy on communication.

Article 13: Searches
The unit did not have a policy on searches. Staff report that there has been no occasion when a search was necessary and that it was unlikely given the population cared for on the unit.

Article 14 (1–5): Care of the Dying
The unit had a policy on care of the dying. There had been a death on the unit since the last inspection and the Mental Health Commission was informed in compliance with the Article.

Article 15: Individual Care Plan
There were no individual care plans. Each resident had a regularly reviewed nursing care plan that was kept separate from the medical notes. Medical notes were computerised and included medical progress notes, the results of physical and psychiatric examinations, and other test results.

Article 16: Therapeutic Services and Programmes
Many of the activities listed under Article 9 were of therapeutic benefit for the residents. However, these activities were not linked to individual assessments of need and there were no references to a therapeutic programme in the care plans.

Article 17: Children’s Education
This Article did not apply as children were not admitted to the unit.

Article 18: Transfer of Residents
There had been no transfers out of the unit since the unit opened. Following the inspection visit, the Inspectorate was sent written policy and procedures for transfers, which had been signed by the senior management team.
with a date of issue (February 2007) and date of review (February 2008).

**Article 19 (1–2): General Health**

Staff reported that the medical officer in the centre conducted a physical examination of each resident every three months. The results of these examinations were recorded in computerised medical files and were reviewed by the Inspectorate. Residents had access to relevant national screening programmes. One resident had received an appointment with the national breast cancer screening service. The unit did not have written policies or procedures in relation to responding to medical emergencies. The Inspectorate was informed that work was being done on a resuscitation policy.

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

The unit did not have written policy and procedures for the provision of information to residents. Staff reported that information on personal possessions and property, meal times and visiting arrangements was communicated verbally to residents. No information was available on advocacy or voluntary agencies. Staff considered that residents were not able to understand and discuss issues relating to their diagnoses, medications and possible side effects of medication and therefore no written information was provided for residents.

**Article 21: Privacy**

The majority of residents had individual rooms with en suite toilet and shower facilities. Residents in shared rooms had curtains around their beds, but those in single rooms did not. All bedrooms had observation panels on the doors that opened onto the corridor. Residents had their own personal lockers and wardrobes. Residents and their visitors had access to the dining room on the ground floor throughout the day.

**Article 22: Premises**

The premises had been purpose built two years previously. The unit was modern, well lit and clean. Staff reported that there were no problems with heating and ventilation. It was reported that the building was still under warranty and that regular checks were made and any remedial work necessary was attended to quickly. The unit was furnished to a high standard. Special mattresses, special chairs and hoists were provided to residents when necessary. The building appeared to be well designed and the safety needs of residents, visitors and staff had been taken into account. There was disabled access, lifts and rails.

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

The centre had a written policy in place on the ordering, storing and administration of medicines, but no written policy on the prescribing of medication.

**Article 24 (1–2): Health and Safety**

An audit had been undertaken by an external company and in response to this a comprehensive safety statement had been put in place for the approved centre. On the day of the inspection, there was no health and safety statement on the unit.
Article 25: Use of Closed Circuit Television (CCTV)

CCTV was used for security reasons and only on the outside of the building. There were signs indicating CCTV was in use. CCTV was not used for observation of residents.

Article 26: Staffing

On the day of the inspection, the Inspectorate did not see policy and procedures relating to recruitment, selection and vetting of staff. This policy was subsequently sent to the Inspectorate and included a date of issue (February 2007) and a date of review (February 2008). The policy did not include a section on Garda vetting of staff. The numbers of staff on duty had been determined in relation to the needs of the residents, though the skill mix was under review. Apart from the Director of Nursing, none of the nursing staff were registered psychiatric nurses. The unit had no occupational therapist, psychologist or social worker. Chiropody services were provided on a regular basis. A dietician provided a service when requested. A member of nursing staff was in charge of the unit at all times. An ongoing programme of education was in place for staff. Only senior management had undertaken training in the Mental Health Act 2001. Copies of the Act, Rules and Regulations were available on the unit.

Table 1: Unit staff levels

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Day (0800h to 1700h)</th>
<th>Day (1700h to 2000h)</th>
<th>Night</th>
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<tbody>
<tr>
<td>Registered general nurses</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Registered psychiatric nurses</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Care staff</td>
<td>5</td>
<td>4</td>
<td>2</td>
</tr>
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</table>

There were two nurses and five care staff rostered for duty during the day. In the evening there was one nursing staff member and four care staff rostered for duty. At night there was one nursing staff member and two care staff rostered for duty.

Article 27: Maintenance of Records

The unit did not have written policy and procedures for the creation of, access to, or retention and destruction of records. While records were maintained in a safe place, those relating to the care planning of residents were not in composite files. Some of the records were written on unheaded paper, and some records were not signed or dated correctly. The records of fire drills and training were incomplete and difficult to follow. An outline of fire safety training was subsequently given to the Inspectorate.

Article 28: Register of Residents

A register of residents was maintained but this did not meet the full requirements of the Article.

Article 29: Operating Policies and Procedures

All the policies and procedures of the centre were in the process of being reviewed and amended to comply with the Regulations. Approximately 12 new policies and procedures were available on the unit. A master file of policies and all new policies in it were signed, dated and had review dates.

Article 30: Mental Health Tribunals

Suitable facilities were available to hold a mental health tribunal. Staff were available to assist residents to attend.

Article 31: Complaint Procedures

Although a written policy and procedures were in place regarding complaints, these needed to be updated. Notices regarding the complaints procedure were
It was reported that mechanical restraint was not used.

**USE OF MECHANICAL RESTRAINT FOR ENDURING SELF-HARM BEHAVIOUR**

A number of residents were restrained using chairs and belts. The Inspectorate was informed that this was due to risk of falling. The Inspectorate was of the view that this form of restraint met the requirements under Part 5 of the Rules (Mental Health Commission) on mechanical restraint and must be recorded as such. The use of mechanical restraint was not prescribed in compliance with Part 5.

**PHYSICAL RESTRAINT**

The Inspectorate was informed that no form of physical restraint was in use on the unit.

**ADMISSION OF CHILDREN**

The unit did not admit children.

**2.4 EVIDENCE OF COMPLIANCE WITH ADMINISTRATION OF MEDICATION – MENTAL HEALTH ACT 2001, SECTION 60**

This section was not applicable as there had been no detained patients.
INTRODUCTION

Hampstead Private Hospital was an approved centre under the Mental Health Act 2001. The purpose of this unannounced inspection was to comment on the quality of care and treatment given to residents in receipt of mental health services and determine the degree and extent of compliance by the approved centre with the Regulations, Codes of Practice and Rules for Treatment (Sections 50 to 55 and 66, Mental Health Act 2001). The Inspectorate also followed up recommendations from the 2006 report, on multidisciplinary team (MDT) functioning and care planning, and spoke to residents where requested.

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

1.1 DESCRIPTION

Hampstead Private Hospital was a 44-bed unit providing continuing care to two distinct groups of male residents, those with dementia and those with enduring mental illness. The unit was located in a large two-storey house on the grounds of an extensive estate. On the day of the inspection, the unit was locked for reasons of resident safety, to prevent wandering. One patient was detained under the Mental Health Act 2001 and there were three Wards of Court. Access to the unit was monitored and controlled by staff.

1.2 RECOMMENDATIONS ARISING FROM THE 2006 REPORT

1. A system of integrated care planning should be introduced.

Outcome: No progress had been made on this recommendation. Separate medical and nursing plans were maintained. Occupational therapy and recreational therapy notes were not recorded in the clinical files.

1.3 MULTIDISCIPLINARY TEAM FUNCTIONING

A consultant psychiatrist with responsibility for the unit visited daily, Monday to Friday. A medical officer provided weekend cover. There were registered nurses and care staff on the unit. There were no formal team meetings or review dates. A GP was contracted to provide annual physical examinations. Routine medical examinations were done on a rota system. The management team reported that they had been unsuccessful in efforts to recruit suitably qualified nurses eligible to register as psychiatric nurses with An Bord Altranais.

1.4 MULTIDISCIPLINARY TEAM CARE PLANS

There were no individual MDT care plans as defined in the Regulations. Each resident had a nursing care plan that was reviewed at set intervals. Current nursing care plans were kept separate from the medical file and but were included in the medical file at three monthly intervals. There were no entries from occupational therapy or recreational therapy staff in the notes reviewed.

1.5 THERAPEUTIC ACTIVITIES

There was a daily recreational activities programme delivered by an activities therapist. Woodworking sessions
were conducted by one of the maintenance personnel. It was reported that an occupational therapist had been appointed in the previous two weeks. There was a particular requirement to address the needs of residents on the ground floor and provide purposeful and appropriate activities. It was reported that the occupational therapist would have input into this unit.

1.9 2007 RECOMMENDATIONS ON THE QUALITY OF CARE AND TREATMENT – MENTAL HEALTH ACT 2001, SECTION 51(1)(b)(i)

1. The recommendation from the 2006 report for a system of integrated care and treatment planning should be addressed.

2. There should be a formal team meeting with minutes and set review dates.

3. All residents should have an individual assessment of need, and appropriate therapeutic services and programmes made available based on the outcomes.

PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE ON 7 MARCH 2007

2.1 EVIDENCE OF COMPLIANCE WITH REGULATIONS 2006 – MENTAL HEALTH ACT 2001, SECTION 52(d)

This part of the report was completed using a number of evidence bases: interviews with senior staff nurses on duty on the day, including the Director of Nursing, and a paper review of all relevant documents on the unit. A self-assessment report had not been completed by the service for the MHC Quality and Standards Division prior to the inspection date. A feedback meeting was held with senior staff after the inspection.

Article 4: Identification of Residents

Each resident was identified by a photograph on medication blister packs. All photos were recently taken. In addition, each resident had a photo on the door of his
room. The unit had a consistent core of nursing and care staff and all residents were well known to the staff.

**Article 5: Food and Nutrition**

There was a supply of bottled drinking water available on the unit. Food was prepared on the hospital campus and transported to Hampstead every day. It was reported that all diets were accommodated. Some residents required a soft diet and provision was made for this.

**Article 6 (1–2): Food Safety**

It was reported to the Inspectorate that an independent company carried out audits of food safety in the unit and that there were also visits from an environmental health officer. A copy of a recent audit dated February 2007 was made available to the Inspectorate.

**Article 7: Clothing**

All residents had their own clothes. On admission, all clothing was labeled, as were subsequent purchases of new clothes. Each resident had his own wardrobe for storing clothes. An inventory of each resident’s clothes was kept in his file. It was the policy of the unit that all residents were dressed during the day. Residents did not wear night clothes during the day.

**Article 8: Residents’ Personal Property and Possessions**

There was a policy and procedure with the title Patients’ Property. This was issued on 1 August 2005 and had a review date of 2 August 2007. An inventory of clothing and valuables was kept in the resident’s file. A facility for the safe keeping of valuables was provided. Clothing and personal items were kept by residents in their lockers and wardrobes.

**Article 9: Recreational Activities**

There was a daily recreation programme on the unit. It was aimed primarily at the residents who could engage in walks, woodwork and cognitively based games. A number of residents with cognitive deficits had limited access to recreational activities appropriate to their needs and abilities.

**Article 10: Religion**

A Roman Catholic chaplain had been employed by the centre and visited the unit at least three times weekly. It was reported that clergy of different denominations visited the unit and that a number of religious services were available to the residents.

**Article 11 (1–6): Visits**

The unit had a detailed operational policy on visits that was issued on 1 October 2005 and was due for review on 1 July 2007. There was a dedicated visitors room, which was bright and nicely decorated, and an enclosed garden that visitors and residents used. Reasonable times were identified during which a resident might receive visits. The safety of residents and their visitors...
were addressed in a number of different ways. Children were allowed to visit, although this was not specified in the policy.

**Article 12 (1–4): Communication**

Residents had access to the postal system and telephone system. A policy and procedures with the title Patient Mail was in place.

**Article 13: Searches**

The operational policies and procedures for searches were contained in a policy with the title Patients’ Property, which was issued on 1 August 2005 and had a review date of 2 August 2007. The procedure met most of the requirements of this Article. There was no operational policy on the finding of illicit substances.

**Article 14 (1–5): Care of the Dying**

A written policy and procedure with the title Death and Dying was issued on 26 August and had a review date of 1 September 2007. It focused mainly on the care of terminally ill residents. No clear procedures were outlined regarding the reporting of a sudden death.

**Article 15: Individual Care Plan**

There were no individual care plans. Each resident had a nursing care plan that was reviewed at set intervals. Current care plans were kept separate from the medical file but were included in the medical file at three-month intervals. Within the main file, there were medical progress notes and the results of physical examinations. There were no entries from occupational therapy or recreational therapy staff in the notes reviewed.

**Article 16: Therapeutic Services and Programmes**

Each resident had access to medical staff, nursing care, and recreational therapy staff. There was a particular requirement to address the needs of residents on the ground floor and provide purposeful and appropriate activities. It was reported that an occupational therapist would have input into the unit within weeks of the inspection.

**Article 17: Children’s Education**

Children were not admitted to this unit.

**Article 18: Transfer of Residents**

A written policy and procedures were in place with the title External and Internal Transfers that had been issued on 2 November 2007 with a date for review of 1 November 2007.

**Article 19 (1–2): General Health**

There was a policy with the title Medical Emergencies in place. There was evidence in the files examined that physical examinations had been completed within the previous six months.
Article 20 (1-2): Provision of Information to Residents

The unit did not have written policy and procedures for the provision of information to residents. However, an information leaflet was given to residents. This detailed the names and roles of relevant staff, housekeeping practices, arrangements for personal property and other relevant information.

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<th>COMPLIANT</th>
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Article 21: Privacy

Many measures were in place to ensure that the privacy and dignity of residents were respected. There was a dedicated visitors room. Many residents had single rooms and those who shared rooms had curtains around their beds and adequate space. There were curtains around the bathing facilities. While the dining room was small for the numbers using it, there was an imminent plan for this area to be enlarged.

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<th>COMPLIANT</th>
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Article 22: Premises

The unit was clean and in good decorative condition. Much of the unit had been repainted recently and new floor coverings had been laid. The unit was well lit, heated and ventilated. There was an ongoing programme of maintenance and refurbishment in place. The unit was furnished to a high standard.

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<th>COMPLIANT</th>
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Article 23 (1-2): Ordering, Prescribing, Storing and Administration of Medicines

A policy with the title Medical Preparations was in place, covering the ordering, prescribing, storing and administration of medicines. This was issued on 22 January 2007 and was due for review on 21 January 2009. A policy with the title Controlled Drugs was issued on the 23 January 2007 and was due for review on the 22 January 2009.

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<th>COMPLIANT</th>
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Article 24 (1-2): Health and Safety

A policy and procedures with the title Accidents/Incidents policy and procedures was in place, issued in October 2005 and due for review in October 2007.

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<tr>
<th>COMPLIANT</th>
<th>YES</th>
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Article 25: Use of Closed Circuit Television (CCTV)

CCTV was not in use on the unit.

Article 26: Staffing

A written Recruitment/Selection policy and procedures were issued on 22 November 2006 with a review date of 24 November 2008. The policy did not include a section on routine Garda vetting for all staff. All applicants from outside the EU who sought a visa to work in Ireland received Garda vetting as part of the process. The management team informed the Inspectorate that the organisation had just been given permission to apply for Garda vetting as a matter of routine. It was planned that a member of staff would undergo the training necessary to implement this.

The main care of the residents was provided by nursing and care staff on the unit and by a consultant psychiatrist who visited daily, Monday to Friday. All nursing staff were registered with An Bord Altranais.
Table 1: Unit staff levels

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered general nurse</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Registered psychiatric nurse</td>
<td>0</td>
<td>(One staff nurse had psychiatric training and all nurses on duty had the support of a night nursing officer with psychiatric training)</td>
</tr>
<tr>
<td>Care staff</td>
<td>7</td>
<td>3</td>
</tr>
</tbody>
</table>

An activities therapist provided a service daily during the week. An occupational therapist had recently been recruited. A registered general nurse was on duty and in charge of the centre at all times. A programme of education and training was in place for staff. This included an induction programme, training on challenging behaviour, manual handling, cardio-pulmonary resuscitation (CPR), MRSA, nutrition, diabetes and fire drills. Nursing staff had received training in care planning. A member of the organisation had completed training as a trainer in the delivery of the Mental Health Act 2001. This had not been rolled out to all staff as yet. A copy of the Rules was available on the unit.

**Article 27: Maintenance of Records**

The service did not have written policy and procedures in place on the creation of, access to, or retention and destruction of records. There was a policy with the title Documentation and Report Writing, which was issued on 1 October 2005 and was due for review on 1 October 2007. The records examined in relation to care of the residents were incomplete and not easy to retrieve. The file of one resident did not contain a care plan and some of the nursing notes were written on unheaded paper. Contrary to the policy, many of the entries did not contain the time of entry or the full signature of the professional concerned. One file did not contain any nursing progress notes for the previous three months. Some of the pages containing progress notes were not in chronological order.

**Article 28: Register of Residents**

The register of residents had not been established. However, there was an admissions book for the unit, which contained most of the information required by Schedule 1.

**Article 29: Operating policies and procedures**

All written operational policies and procedures in the centre were reviewed two years after the date of issue.

**Article 30: Mental Health Tribunals**

Arrangements were in place for full cooperation with mental health tribunals. The unit had had its first mental health tribunal just prior to the inspection.

**Article 31: Complaint Procedures**

A policy and procedures in relation to complaints were issued on 24 January 2007 and were due for review on 23 January 2009. Residents were made aware of their right to complain. Details of the complaints procedure were in the information leaflet that was provided to residents and their carers. Notices regarding the complaints procedure were also displayed in the centre. The Director of Nursing was the person nominated to deal with complaints. Complainants were written to in relation to their complaint within 15 days and records were kept of all complaints. These were examined by the Inspectorate.
Article 32: Risk Management Procedures

There was no comprehensive risk management policy in place. However, there were several individual policies on various aspects of risk management.

<table>
<thead>
<tr>
<th>Article 32: Risk Management Procedures</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES ✓ NO</td>
</tr>
</tbody>
</table>

Article 33: Insurance

A copy of the insurance certificate was given to the Inspectorate during the inspection.

<table>
<thead>
<tr>
<th>Article 33: Insurance</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES ✓ NO</td>
</tr>
</tbody>
</table>

Article 34: Certificate of Registration

The certificate was displayed on the wall in the entrance to the centre.

<table>
<thead>
<tr>
<th>Article 34: Certificate of Registration</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES ✓ NO</td>
</tr>
</tbody>
</table>

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

SECLUSION

It was reported to the Inspectorate that seclusion was not used on the unit.

ECT

ECT was not provided on the unit or in the hospital complex. Residents requiring ECT were transferred to an external hospital.

MECHANICAL RESTRAINT

It was reported to the Inspectorate that mechanical restraint was not used on the unit.

USE OF MECHANICAL RESTRAINT FOR ENDURING SELF-HARM BEHAVIOUR

The Inspectorate was informed that a number of residents had ongoing risk of falling and that chairs and belts were used for their safety. The Inspectorate was of the view that this form of mechanical restraint met the requirements under Part 5 of the Rules and must be recorded as such. In the clinical file inspected, this form of restraint had been recorded in compliance with Part 5.

<table>
<thead>
<tr>
<th>Article 32: Risk Management Procedures</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES ✓ NO</td>
</tr>
</tbody>
</table>

2.3 EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001, SECTION 51(1)(b)(iii)

PHYSICAL RESTRAINT

The Inspectorate was informed that no form of physical restraint was in use on the unit.

ADMISSION OF CHILDREN

The unit did not admit children.
1.2 RECOMMENDATIONS ARISING FROM THE 2006 REPORT

1. A system of integrated care and treatment planning must be put in place.

Outcome: The unit did not have a core multidisciplinary team. There was no clinical psychologist or social worker. Although there was evidence of medical, nursing and occupation therapy care and treatment plans and review meetings, each discipline kept separate care and treatment plans and case notes.

1.3 MULTIDISCIPLINARY TEAM FUNCTIONING

A consultant psychiatrist with responsibility for the unit visited daily, Monday to Friday. Each resident had a primary nurse who communicated the resident’s progress at the daily ward round meetings. There was also an occupational therapist and an activity staff member. Review meetings were held every three to six months and attended by the consultant psychiatrist, nursing and activity staff, and the occupational therapist. Decisions were recorded in the medical and nursing files. Referral to the occupational therapy service, which was provided three days a week, was through the consultant. A primary care doctor was on call to attend to the physical needs of residents. Residents had access to a range of other therapists, including a chiropodist, physiotherapist, optician and dentist. A nutritionist had just started in the unit.
1.4 MULTIDISCIPLINARY TEAM CARE PLANS

There was evidence in the files examined by the Inspectorate that residents had up-to-date medical, nursing and occupational therapy care plans. However, these care plans were not integrated and there was limited core multidisciplinary team input. Two sets of files were kept on each resident. Nursing entries were made in a nursing file, while other disciplines used the medical files. There was no indication that the service was moving towards integrated care planning.

1.5 THERAPEUTIC ACTIVITIES

There was evidence in the files examined by the Inspectorate that residents attended activities and therapeutic programmes as outlined in their medical, nursing and occupational therapy care plans.

1.6 ENVIRONMENT AND FACILITIES

The premises were well maintained and clean with adequate lighting, heat and ventilation. There were two maintenance staff on site and staff reported that repairs were carried out in a timely fashion. Furniture on the unit was being refurbished on a phased basis. A range of furnishings was provided to facilitate different activities and some residents had been measured for special chairs. There was disabled access to the building. Two rooms were used for high observation and contained a space for a nurse to be present.

1.7 INTERVIEWS WITH RESIDENTS

None of the residents asked to meet formally with the Inspectorate. However a number of residents spoke to the Inspectorate during the inspection of the environment.

1.8 GOOD PRACTICE DEVELOPMENTS

1. All residents had a manual handling chart and a handling risk assessment and it was planned to integrate these into the nursing care plans.

2. The nursing care plans were reviewed every one to two weeks by the consultant psychiatrist, ward sister, care assistants and activities staff.

3. A new shower unit and hoist had been purchased.

4. Where there was a need for food to be liquidised, the meat, vegetables and potatoes were blended and presented separately, which enhanced the visual appeal of the meal.

5. There was a new activity staff member working Monday to Friday from 0900h to 1700h.

6. Five care staff have received FETAC qualifications since the last inspection.

7. The furniture in the unit was being refurbished on a phased basis.

8. Collapsible curtain rails around the beds were being installed on a phased basis.

1.9 2007 RECOMMENDATIONS ON THE QUALITY AND CARE OF TREATMENT – MENTAL HEALTH ACT 2001, SECTION 51(1)(b)(i)

1. A system of integrated care and treatment planning should be put in place.
PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE ON 7 MARCH 2007

2.1 EVIDENCE OF COMPLIANCE WITH REGULATIONS 2006 – MENTAL HEALTH ACT 2001, SECTION 52(d)

This part of the report was completed using a number of evidence bases: interviews with senior staff nurses on duty on the day, interviews with the Director of Nursing, the CEO and the consultant psychiatrist, and a paper review of all relevant documents on the unit and in the hospital. A self-assessment report had not been completed and returned to the MHC Quality and Standards Division prior to the inspection date. A feedback meeting was held with senior staff after the inspection.

Article 4: Identification of Residents

Residents were provided with identification wristbands. Charts and drug prescription cards included the name and photo of the respective resident. There was a bedside card containing the name and photo of the resident. The unit had a consistent population of residents and the unit was self-staffed, so the staff group knew all the residents. Staff who administered medication were observed by the Inspectorate to be able to identify each resident by name.

Article 5: Food and Nutrition

There was a water dispenser attached to the mains water supply, which provided cold and chilled water. The meal times were organised to facilitate residents. Breakfast began at 0900h and other meals were spaced at regular intervals throughout the day. There was a choice of meat, fish and vegetables for dinner. The CNM1 reported that she advised catering staff of any special dietary requirements. Food was liquidised as required, consistent with care plans and each element of the meal was liquidised separately to maintain the visual appeal of the food. At dinner time on the day of the inspection, some residents were observed to change their minds about their choice of food and this was facilitated by staff.

Article 6 (1–2): Food Safety

This was not inspected on the day. The Inspectorate subsequently received documentation from a private food hygiene company. This indicated a programme of ongoing audit, monitoring and improvement of food standards was in place.

Article 7: Clothing

The unit had a policy on possessions, which included clothing. An individualised list of each resident’s clothes was kept in a file in the nurses’ office. The hospital had made funds available when necessary to buy new clothes, and residents were involved in selecting their own clothes if they wished. On occasion, staff had donated good quality second-hand clothes, which were cleaned in the hospital laundry. All clothing was sent to the seamstress, who attached name labels to each item. All of the residents observed were adequately dressed. Staff reported that residents were encouraged to wear day clothes during the day. None of the residents was observed to be wearing night clothes during the inspection visit.

Article 8: Residents’ Personal Property and Possessions

The unit had a written Patient’s Property policy and procedures, issued on 1 January 2005 with a review date of 2 August 2007. The policy covered clothing, valuables, money, and there was also a policy on possession of sharp objects by patients. A list of personal possessions stored in
the nurses’ office was made available to the Inspectorate. This was kept separate to individual care plans. Individual lockers and wardrobes for the storage of clothing and personal items were available to residents in the bedrooms. Residents were advised not to bring valuable items and large sums of money into the unit. Valuable items and money were routinely deposited in a designated location and deposits were signed by two nursing staff.

**Article 9: Recreational Activities**

A range of recreational activities were provided both on the unit and in the local community, including bingo, sing-songs, and trips to local shops. There was a policy with the title Escort for Recreational Activity.

**Article 10: Religion**

A Roman Catholic chaplain provided services to the unit. Representatives of various denominations visited the unit as requested by residents or families. At the time of the inspection, a Roman Catholic priest and a Church of Ireland minister were attending residents.

**Article 11 (1–6): Visits**

Visits were discouraged at meal times to facilitate residents; otherwise visits were permitted until 2030h. The Inspectorate observed signs at the front door indicating visiting times and arrangements. The unit had a number of policies relating to the health and safety of staff, visitors and residents and there was a log for visitors to complete upon arrival and departure for fire and safety purposes. Families were encouraged to visit and a number of areas facilitated privacy, including the day rooms, bedrooms and gardens. There was sufficient space in bedrooms, day rooms and gardens to facilitate children, although there was no designated children’s visiting area. The Inspectorate was furnished with an up-to-date written operational policy and procedures in relation to visits, which were issued on 1 October 2005 and were due for review on 1 September 2007.

**Article 12 (1–4): Communication**

A public phone was provided in a private area for residents. A written Patient Mail policy and procedures were in place, which specified that outgoing mail was brought by staff to a general office to be posted. Incoming mail was distributed unopened to residents. There was access to fax if required, but no internet or email access.

**Article 13: Searches**

The unit had a written Patients’ Possessions policy, which included a procedure for conducting searches, both with and without consent. However, there was no specific written policy on searches. The written procedure for searches was consistent with this Article. Staff reported that routine searches were not carried out on the unit and that searches were infrequent. There was no evidence that indicated a method of ensuring that staff and residents were aware of the procedures in relation to searches. The procedure for searches indicated that two nursing staff were to be in attendance during searches and that residents must be informed of what is happening and why. The unit’s procedure for searches outlined steps which indicated that a written record be made of the search and the reasons for it. Although the unit had a Drug and Alcohol Statement, there was no policy in relation to the finding of illicit substances. It was reported that this was an unlikely event given the population of the unit.
Article 14 (1–5): Care of the Dying

The Inspectorate was furnished with the unit’s Death and Dying policy and procedures issued 26 August 2005 and due for review on 1 September 2007. The policy did not indicate the requirement for all deaths to be notified to the Mental Health Commission.

Article 15: Individual Care Plan

There was evidence in the files examined by the Inspectorate that residents had up-to-date medical, nursing and occupational therapy care plans. However, these care plans were not integrated and there was limited core multidisciplinary team input. There was no indication that the service was moving towards integrated care planning.

Article 16: Therapeutic Services and Programmes

There was evidence in the files examined by the Inspectorate that residents attended activities and therapeutic programmes as outlined in their medical, nursing and occupational therapy care plans.

Article 17: Children’s Education

This Article was not applicable as the unit did not admit children.

Article 18: Transfer of Residents

The unit had written policy and procedures for the transfer of residents both within the hospital and to and from external agencies.

Article 19 (1–2): General Health

Staff reported that a GP routinely visited once a year and there was evidence in the files inspected that residents had had medical reviews within the last six months. Residents had attended specialist consultant appointments elsewhere as required. Dental appointments were provided locally or in the unit. Access was available to specialist geriatric services as required. Residents had access to the national breast cancer screening programme. The unit had a written policy and procedures for responding to medical emergencies.

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

Residents were not routinely given information about their multidisciplinary team or key nurse. It was reported that leaflets containing information about the unit were given to families prior to admission but were not routinely available to residents on the unit. Staff reported that information about diagnosis was not routinely given to the resident. The Inspectorate observed information leaflets displayed on the unit from the Irish Advocacy Network and other agencies. Information on medication and possible side effects was not routinely made available to residents. The unit did not have policy and procedures for the provision of information to residents.

Article 21: Privacy

There were a number of single bedrooms. The double bedrooms inspected had curtains around each bed. All bedroom windows had curtains. Bathroom facilities provided for privacy and dignity.
Article 22: Premises

On the day of the inspection, the premises were well maintained and clean with adequate lighting, heat and ventilation. There were two maintenance staff on site and staff reported that repairs were carried out in a timely fashion. Furniture on the unit was being refurbished on a phased basis. There was evidence of a range of furnishings to facilitate different activities and some residents had been measured for special chairs. There was disabled access to the building. Two rooms were used for high observation, with space for a nurse to be present.

COMPLIANT  YES ✔  NO

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

The Medical Preparations policy related to controlled drugs and to ordering, storing and administration of medicines. It was issued in January 2007 with a review date in January 2009.

COMPLIANT  YES ✔  NO

Article 24 (1–2): Health and Safety

The unit had a number of policies concerning the health and safety of residents, visitors and staff, including Accident/Incident Policy, Security Policy, Safe Work Practice and Abuse of Older People. Each policy had a clear date of issue and date of review.

COMPLIANT  YES ✔  NO

Article 25: Use of Closed Circuit Television (CCTV)

CCTV was used externally on the grounds for security purposes only. It was not used for the observation of residents.

COMPLIANT  YES ✔  NO

Article 26: Staffing

The unit had a written Recruitment/Selection policy and procedures issued on 22 November 2006 and due for review on 24 November 2008. This did not include a section on the Garda vetting of staff. The senior management team informed the Inspectorate that all staff from outside the EU automatically received Garda vetting as part of the visa process. There was no psychiatric nursing, clinical psychology or social work input. A registered general nurse was in charge of the centre at all times. The management team reported that there had been unsuccessful efforts to recruit suitably qualified nurses who are eligible to register as psychiatric nurses with An Bord Altranais.

Table 1: Unit staff levels

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered general nurse</td>
<td>2 (minimum) and access to Assistant Director of Nursing</td>
<td>2 (and access to night nursing officer)</td>
</tr>
<tr>
<td>Registered psychiatric nurse</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Qualified care staff</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Unqualified care staff</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

A programme of education and training was in place for staff. This included an induction programme, training on challenging behaviour, manual handling, cardio-pulmonary resuscitation (CPR), MRSA, nutrition, diabetes and fire drills. Nursing staff had received training in care planning. One member of staff had completed training as a trainer in the delivery of the Mental Health Act 2001. To date this had not been rolled out to other staff. Copies of the Act and the Regulations were available on the unit.

COMPLIANT  YES ✔  NO

Article 27: Maintenance of Records

The files examined by the Inspectorate were in good order. They were stored in a filing cabinet in a locked office. The files were easy to retrieve and were sorted.
were set out in the information leaflet given to families at admission. Notices regarding the complaints procedure were also displayed in the centre. The Director of Nursing was designated to deal with complaints and the policy stated that complaints would be investigated within 15 days. Records were kept of complaints that had been received and this was examined by the Inspectorate.

**Article 32: Risk Management Procedures**

There was no comprehensive risk management policy in place. However, there were several individual policies on the various aspects of risk management required under this Article.

**Article 33: Insurance**

A copy of the insurance certificate was made available to the Inspectorate.

**Article 34: Certificate of Registration**

The certificate of registration was displayed in the reception area.

### 2.2 Evidence of Compliance with Rules – Mental Health Act 2001, Section 52(d)

#### Seclusion

The service reported that seclusion was not used.
ECT

This unit did not provide ECT. In circumstances when residents had required ECT this had been provided by other services.

MECHANICAL RESTRAINT

The service reported that mechanical restraint was not used in the centre.

USE OF MECHANICAL RESTRAINT FOR ENDURING SELF-HARM BEHAVIOUR

A number of residents were restrained using chairs and belts. The Inspectorate was informed that this was because of risk of falling. The Inspectorate was of the view that this form of restraint was covered by Part 5 of this Rule. The unit was compliant with the requirements of Part 5.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

2.4 EVIDENCE OF COMPLIANCE WITH ADMINISTRATION OF MEDICATION – MENTAL HEALTH ACT 2001, SECTION 60

This was not applicable as there were no detained patients in the unit.

2.3 EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001, SECTION 51(1)(b)(iii)

PHYSICAL RESTRAINT

The service reported that physical restraint was not used on this unit. All staff were trained in breakaway techniques.

ADMISSION OF CHILDREN

This section was not applicable as the unit did not admit children.
planned that the service would move to Bloomfield Care Centre, Rathfarnham, in the future.

1.2 RECOMMENDATIONS ARISING FROM THE 2006 REPORT

1. Each patient should have an overall individual care plan and treatment plan.

   **Outcome:** No progress had been made on introducing individual multidisciplinary care plans.

2. The occupational therapist should integrate her notes into the main care plan including individual assessment and goals for each patient.

   **Outcome:** The occupational therapist was writing in the nursing care plan.

3. Each patient must have an annual physical examination.

   **Outcome:** There had been no progress on this recommendation.

4. Each patient should have an individual financial account and the clinic should have a written policy detailing financial procedures.

   **Outcome:** A policy for giving residents pocket money was in place. When money was lodged to the hospital, there were designated individuals who could withdraw money from residents’ accounts. Residents did not sign for their money and did not receive a written financial statement from the clinic.

5. Policies should be signed, dated and a review date set.

   **Outcome:** Policies were signed and dated and a system for reviewing policies was in place.

6. Patients and relatives should continue to be informed of the progress to move to a new site at regular intervals.
Outcome: This recommendation had been met.

7. All staff should be facilitated to complete Mental Health Act 2001 training.

Outcome: None of the staff were trained in the Mental Health Act 2001.

1.3 MULTIDISCIPLINARY TEAM FUNCTIONING

There were general nurses, a part-time occupational therapist and a number of care workers. Consultant psychiatrists and one general practitioner attended the unit weekly. There were no registered psychiatric nurses in the service. Clinical meetings were held between the consultant psychiatrists and nursing staff. The occupational therapist did not attend these meetings but met informally with nursing staff.

1.4 MULTIDISCIPLINARY TEAM CARE PLANS

The service did not have MDT care plans as described in the Regulations. Nursing and medical care plans were maintained separately. The care plans were re-assessed monthly and reviewed weekly.

1.5 THERAPEUTIC ACTIVITIES

Although the service provided therapeutic programmes, these were not linked to an MDT care plan. Some of the residents were not able to attend the programmes.

1.6 ENVIRONMENT AND FACILITIES

The unit was clean and in good decorative order. A cleaner was employed on the unit. Staff reported that repairs and emergency maintenance were carried out promptly. Routine maintenance was carried out every week. The furnishings were appropriate to the needs of the residents. The unit was well lit, heated and ventilated. Within the next two years, it was planned that the unit would close and move to Bloomfield in Rathfarnham.

1.7 INTERVIEWS WITH RESIDENTS

The Inspectorate spoke with a number of residents. All stated that they were happy with the service, food and accommodation.

1.8 POSITIVE DEVELOPMENTS

1. The occupational therapist had commenced recording therapy plans and interventions in the nursing care plan.

2. The service planned to recruit a CNM2, and stated a preference for a nurse with psychiatric training.

1.9 2007 RECOMMENDATIONS ON THE QUALITY OF CARE AND TREATMENT – MENTAL HEALTH ACT 2001, SECTION 51(1)(b)(i)

1. Each resident should have an overall individual care plan and treatment plan.

2. Each resident should have a physical examination every six months as required by the Regulations.

3. Each resident should have an individual financial account and the clinic should have a written policy detailing financial procedures.

4. Residents and relatives should continue to be informed about progress in relation to move.

5. All staff should be facilitated to complete Mental Health Act 2001 training.
PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE ON 3 APRIL 2008

2.1 EVIDENCE OF COMPLIANCE WITH REGULATIONS 2006 – MENTAL HEALTH ACT 2001, SECTION 52(d)

This part of the report was completed using a number of evidence bases: a self-assessment report completed by the service and submitted to the MHC Quality and Standards Division prior to the inspection date, interviews with the Director of Nursing, General Manager and CNM1, and a review of all relevant documents in the clinic.

Article 4: Identification of Residents

Nursing staff were permanently rostered to the unit and the resident population changed little over time, so the residents were well known and easily identified by staff. Residents’ names were placed over their beds.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>✓</td>
<td></td>
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</table>

Article 5: Food and Nutrition

The service reported that fresh water and juice were provided in jugs and left in the sitting rooms and on lockers for the residents. This was not in evidence at the time of the inspection. There was a choice of menu that changed every two weeks. Food was prepared on site.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td></td>
<td>✓</td>
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</table>

Article 6 (1–2): Food Safety

This was not inspected on the day.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td></td>
<td>✓</td>
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</table>

Article 7: Clothing

Staff reported that relatives were asked to provide appropriate clothes for residents. Laundry facilities were on site. Most of the residents’ clothes were labeled. None of the residents were in night clothes during the day.

Article 8: Residents’ Personal Property and Possessions

No written operational policy or procedures were in place relating to residents’ personal property and possessions. A list of residents’ property and possessions was maintained in the central office. Residents kept their own personal possessions. Dangerous or valuable items were given to families or stored by the clinic. A safe facility for valuables was provided by the clinic.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
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<tr>
<td></td>
<td>✓</td>
<td>✓</td>
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</table>

Article 9: Recreational Activities

Some residents attended day centres. Residents could go to a Sonas group, music sessions that were provided three days a week, and small group outings that were arranged regularly. Physical exercise was encouraged and facilitated.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>✓</td>
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</table>

Article 10: Religion

There were monthly Church of Ireland and Roman Catholic services in the clinic. Other religions could be catered for if needed.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td></td>
<td>✓</td>
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</table>
Article 11 (1–6): Visits

Visitors, including children, were facilitated in a large sitting room and in individual bedrooms. Visiting times were not restricted and were displayed. Details on visiting were in a policy dated February 2007.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

Article 12 (1–4): Communication

A public phone booth was provided for residents. Residents’ post was not opened. The service did not have written policy or procedures on communication.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
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Article 13: Searches

The service did not have a written policy or procedures for searching residents or their belongings or for finding illicit substances. Staff reported that searches were rarely carried out. Evidence of a system to ensure that the consent of the resident was sought for searches and that there was a minimum of two staff present during searches was not available. There was no record kept of searches.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
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</table>

Article 14 (1–5): Care of the Dying

Written policy and protocols were in place for the care of residents who were dying. The policy did not include the requirement to inform the Mental Health Commission of the death of any resident within 48 hours, or to inform the coroner. Following the inspection the clinic amended its policy, which was then submitted to the Inspectorate.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

Article 15: Individual Care Plan

Individual care plans were not in place. Separate nursing care plans and medical treatment files were kept. The occupational therapy notes had not been signed. The care plans were re-assessed monthly and reviewed weekly.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

Article 16: Therapeutic Services and Programmes

An occupational therapist attended four days a week and provided group and individual work. However, not all residents could attend.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

Article 17: Children’s Education

As the clinic did not admit children, this Article was not applicable.

Article 18: Transfer of Residents

Detailed policy and procedures for transferring residents were in place.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

Article 19 (1–2): General Health

A GP attended the unit every week and an on-call system was available. No evidence of routine physical examinations was available. Some of the residents had received breast cancer screening. No written operational policy or procedures were in place for responding to medical emergencies.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>
Article 20 (1–2): Provision of Information to Residents

No written policy and procedures were in place for the provision of information to residents. Residents had not been given access to written information about the hospital or about their illness.

| COMPLIANT | YES ✓ | NO ✓ |

Article 21: Privacy

The layout of the bedrooms, the availability of single rooms and the use of dividing curtains in double rooms provided privacy for the residents.

| COMPLIANT | YES ✓ | NO |

Article 22: Premises

Although the building was old, the unit was clean and in good decorative order, with appropriate furnishings. It was well lit, heated and ventilated. Weekly maintenance was carried out. A cleaner was employed. Within the next two years the clinic will move to Bloomfield in Rathfarnham.

| COMPLIANT | YES ✓ | NO |

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

A policy on the schedule of controlled drugs and guidelines for administration of medicines were in place. There was a system for reporting medication errors. A locked medication trolley was secured to the wall. Some prescriptions required updating and clarification with relation to the prescription date.

| COMPLIANT | YES ✓ | NO |

Article 24 (1–2): Health and Safety

A health and safety policy was in place.

| COMPLIANT | YES ✓ | NO |

Article 25: Use of Closed Circuit Television (CCTV)

CCTV was not used.

Article 26: Staffing

The policies in relation to staffing were being developed. The clinic had no registered psychiatric nurses. There was a CNM1 on duty 18 hours a week.

| COMPLIANT | YES ✓ | NO |

Table 1: Unit staff levels

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Day (0830h to 1630h)</th>
<th>Day (1630h to 2030h)</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered general nurse</td>
<td>2–4</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Registered psychiatric nurse</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Care worker</td>
<td>5–7</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

A manual handling course was run every two years. The service was planning to develop cardio-pulmonary resuscitation (CPR) training. None of the staff had been trained in the Mental Health Act 2001. All copies of the Act, Regulations and Rules were held in the main office.

| COMPLIANT | YES ✓ | NO |

Article 27: Maintenance of Records

All documentation was neat and tidy. There were no policies for creation, access to, or retention and destruction of records. Health and safety records were maintained in the main office.

| COMPLIANT | YES ✓ | NO |

Mental Health Commission Annual Report 2007 | 33
Article 28: Register of Residents
The clinic used a large logbook that did not contain all the required information. However, during the inspection an alternative register was developed on a spreadsheet and contained all relevant information.

**COMPLIANT**

Article 29: Operating policies and procedures
The policies that were in place had no review date specified. A number of policies that were required under the Regulations were not available.

**COMPLIANT**

Article 30: Mental Health Tribunals
The clinic did not accept detained patients.

Article 31: Complaint Procedures
There was a complaints policy and procedure in place and the complaints procedure was displayed in the reception area. The Director of Nursing was the nominated person to receive complaints. The Board of Management reviewed complaints at its monthly meeting. There was no time frame specified for the investigation of complaints in the policy. No complaints had been received in the last 12 months.

**COMPLIANT**

Article 32: Risk Management Procedures
There was no overall risk management policy in place. The service had policies about locking doors, patients absent without leave, suicide (dated 1999) and recording injury to staff, residents and visitors. All adverse incidents were recorded and there was an incident form specifically for reporting adverse events to the MHC. A policy for responding to emergencies and the Trust in Care policy were not in place.

**COMPLIANT**

Article 33: Insurance
The insurance policy was made available to the Inspectorate.

**COMPLIANT**

Article 34: Certificate of Registration
The certificate of registration was displayed in the reception area.

**COMPLIANT**

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

**SECLUSION**
The service reported that seclusion was not used.

**ECT**
The service reported that ECT was not used.

**MECHANICAL MEANS OF BODILY RESTRAINT**
The service reported that mechanical restraint was not used on the unit.
USE OF MECHANICAL RESTRAINT FOR ENDURING SELF-HARM BEHAVIOUR

Cot sides on beds were the only mechanical means of bodily restraint used for enduring self-injurious behaviour. Part 5 of the Rules, which applied in these instances, was not fully complied with, as it was not prescribed by the consultant psychiatrist.

| COMPLIANT | YES | NO | ✓ |

2.3 EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001, SECTION 51(1)(b)(iii)

PHYSICAL RESTRAINT

The Inspectorate was informed that no form of physical restraint was in use on the unit.

ADMISSION OF CHILDREN

The unit did not admit children.

2.4 EVIDENCE OF COMPLIANCE WITH ADMINISTRATION OF MEDICATION – MENTAL HEALTH ACT 2001, SECTION 60

This was not applicable as there were no detained patients.
PALMERSTOWN VIEW, STEWART’S HOSPITAL

1.2 RECOMMENDATIONS ARISING FROM THE 2006 REPORT

1. The function and purpose of the unit needs to be defined.

2. There needs to be a five-year strategic plan specifically for mental health services in this area.

   Outcome: These two recommendations were linked. The service applied for Palmerstown View to be an approved centre under the Mental Health Act 2001. All of the current residents had long-term needs that could have been provided outside an approved centre, however there was no such facility. No five-year plan had been developed.

3. There should be a fully staffed multidisciplinary team dedicated to mental health services in Stewart’s Hospital.

   Outcome: Staff on the unit reported that an Assistant Director of Nursing had been assigned responsibility for Palmerstown View and that a consultant psychiatrist and NCHD attended weekly meetings on the unit. Following the inspection, the senior management team informed the Inspectorate that there was a core dedicated multidisciplinary team.

4. An advocacy service to the unit needs to be developed.

   Outcome: No advocacy service had been developed or offered to the residents.

5. A multidisciplinary team care plan needs to be developed and recording streamlined to ensure that necessary information is captured and that the chart remains tidy and easy to access. Consideration might be given to starting a computer record system.

   Outcome: The staff interviewed reported that a working group had been established to develop individual mental health care plans incorporating treatment plans and nursing care plans. There was no time frame available for completion.

INTRODUCTION

Palmerstown View, Stewart’s Hospital, was an approved centre under the Mental Health Act 2001. The purpose of this unannounced inspection was to comment on the quality of care and treatment given to residents in receipt of mental health services and determine the degree and extent of compliance by the approved centre with the Regulations, Codes of Practice and Rules for Treatment (Sections 50 to 55 and 66, Mental Health Act 2001). The Inspectorate also followed up recommendations from the 2006 report, on multidisciplinary team (MDT) functioning and care planning, and spoke to residents where requested.

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

1.1 DESCRIPTION

The unit had six integrated beds. On the day of the inspection, there were six residents. No one was detained under the Mental Health Act 2001. The residents ranged in age from 18 to 54 years and had been resident in the unit for long periods of time. All the residents had a dual diagnosis of intellectual disability and mental illness.
1.6 ENVIRONMENT AND FACILITIES

The unit, which was built in the nineties, did not meet the needs of the residents and a new purpose-built unit was under consideration by the service. The premises were clean and well kept and the decor was of reasonable standard. The furnishings were sparse but appropriate for the needs of the residents.

1.7 INTERVIEWS WITH RESIDENTS

The majority of residents were off site attending day programmes during the inspection. None of the residents asked to meet with the Inspectorate.

1.8 GOOD PRACTICE DEVELOPMENTS

1. A dedicated MDT for mental health.

1.9 2007 RECOMMENDATIONS ON THE QUALITY OF CARE AND TREATMENT- MENTAL HEALTH ACT 2001, SECTION 51(1)(b)(iii)

1. The outstanding five recommendations from the 2006 report should be addressed.
PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE ON 16 FEBRUARY 2007

2.1 EVIDENCE OF COMPLIANCE WITH REGULATIONS 2006 – MENTAL HEALTH ACT 2001, SECTION 52 (d)

This part of the report was completed using a number of evidence bases: a self-assessment report completed by the service and submitted to the MHC Quality and Standards Division prior to the inspection date, interview with senior staff nurses on duty on the day, and a paper review of all relevant documents on the unit.

Article 4: Identification of Residents

Each drug prescription file had a photograph of the resident. Nursing staff were permanently rostered to the unit and the resident population changed little over time, so the residents were well known to and easily identified by staff.

| COMPLIANT | YES | ✓ | NO |

Article 5: Food and Nutrition

There was a supply of tap water on the unit. Food was prepared using a cook-chill method. Staff reported that the food was satisfactory and an element of choice was provided. Special dietary needs were catered for. Meal times were regular and evenly spaced throughout the 24-hour period.

| COMPLIANT | YES | ✓ | NO |

Article 6 (1–2): Food Safety

This was not inspected on the day.

| COMPLIANT | YES | ✓ | NO |

Article 7: Clothing

All residents had their own clothing. There were guidelines in place on personal clothing and there was a clothing list in each case file. Wherever possible community facilities were used to purchase clothing and the resident was involved. It was not policy within this unit to have residents dressed in their night clothes during the day.

| COMPLIANT | YES | ✓ | NO |

Article 8: Residents’ Personal Property and Possessions

While the unit had guidelines regarding personal property and possessions, there was no written operational policy. A record book of property was kept and there was provision for the safe keeping of valuables. Residents had individual financial accounts that their benefits were paid into.

| COMPLIANT | YES | ✓ | NO |

Article 9: Recreational Activities

There were a number of recreational activities available to residents on the unit, e.g. TV, music and videos. It was also evident that a number of activities were organised in the community, including outings and holidays.

| COMPLIANT | YES | ✓ | NO |

Article 10: Religion

It was reported that a number of religious services were available to the residents.

| COMPLIANT | YES | ✓ | NO |
Article 11 (1–6): Visits

A written operational policy regarding visits was in place. The unit endeavoured to ensure the safety of visitors to the unit. The facilities for visitors were poor; there were no dedicated areas and visits took place in a small dining room. All decisions to allow children to visit the unit were made at the MDT meeting.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
<th>✓</th>
</tr>
</thead>
</table>

Article 12 (1–4): Communication

A written operational policy had recently been implemented within the unit. Residents had access to the office telephone on request and to postal services.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>✓</th>
<th>NO</th>
</tr>
</thead>
</table>

Article 13: Searches

The unit had guidelines on searching a resident but did not have an operational policy or consent procedure. It was reported that unit staff rarely carried out searches of residents or their belongings. The service did not have policy or procedures in relation to the finding of illicit substances. It was reported that the current group of residents were unlikely to use illicit substances.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
<th>✓</th>
</tr>
</thead>
</table>

Article 14 (1–5): Care of the Dying

The unit had not had written operational policy and protocols, though there were guidelines in place.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
<th>✓</th>
</tr>
</thead>
</table>

Article 15: Individual Care Plan

There were no individual care plans as required by the Article. The nursing care plans had not been reviewed despite concerns expressed by the Inspectorate in the 2006 report. The service reported that a committee had been established to focus on the development and implementation of individual care plans in the unit.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
<th>✓</th>
</tr>
</thead>
</table>

Article 16: Therapeutic Services and Programmes

While each resident who attended the day services within the hospital had an individual programme, this was not directly linked to an individual care plan.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
<th>✓</th>
</tr>
</thead>
</table>

Article 17: Children’s Education

It was unit policy not to admit children under the age of 18.

Article 18: Transfer of Residents

It was reported that the next of kin was informed of any transfer of the resident. The unit did not have written policy and procedures on the transfer of residents. The service reported that they were in the process of developing policies on admissions, transfers and discharges in line with the Mental Health Act 2001. A time scale for the implementation of these policies was not specified.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
<th>✓</th>
</tr>
</thead>
</table>

Article 19 (1–2): General Health

The hospital had a contract with a local GP practice and the residents had access to this practice. While each resident had an annual physical examination, the Regulations require that this be provided every six months. There were procedures in place for responding to medical emergencies.

| COMPLIANT | YES | NO | ✓ |
Article 20 (1–2): Provision of Information to Residents

Information leaflets were not available to the residents, their family or an advocate. The unit recognised the need to develop these and to have the speech and language department involved to assist in ensuring that information would be presented in ways appropriate to the needs of the residents. The service had draft guidelines regarding the provision of information to residents but not an operational policy.

COMPLIANT: YES

Article 21: Privacy

The unit had adequate facilities to ensure privacy, with the exception of one twin bedroom. There were no separate dedicated facilities for visits.

COMPLIANT: YES

Article 22: Premises

It was reported by the service that the unit was built in 1996 and while it had undergone many developments it fell short in meeting the needs of the residents. There had been discussions within the service regarding a new purpose-built unit. The current unit consisted of a lounge, dining room, small kitchen, four single bedrooms, one twin bedroom, adequate bathing and toilet facilities, a seclusion room, an activity room and nurses office. The unit was clean and well ventilated. The heating was adequate, although was not controlled by thermostat. The decor was of reasonable standard. The furniture, although sparse, was adequate to meet the needs of the residents. The unit was accessible for people with poor mobility. It was reported that routine maintenance could be problematic.

COMPLIANT: YES

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

A review group had been established to develop written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.

COMPLIANT: YES

Article 24 (1–2): Health and Safety

The unit had a safety statement in place.

COMPLIANT: YES

Article 25: Use of Closed Circuit Television (CCTV)

While the unit had guidelines regarding the use of CCTV, it did not have an operational policy. The issue of notification of the use of CCTV in the unit was complex in that a number of the residents cannot read. The speech and language department was working with the unit to develop a system of appropriate signage. CCTV was used to monitor the seclusion room and one single bedroom. No recordings were made and the monitor was in the nurses’ office.

COMPLIANT: YES

Article 26: Staffing

It was reported that the hospital had policies on recruitment, selection and vetting of staff. There was a CNM2 in charge of the unit and a consistent group of nursing and care staff. There was MDT input into the unit. There were no qualified staff on duty at night in Palmerstown View. There was a night superintendent and nursing team for the hospital.

COMPLIANT: YES
Table 1: Unit staff levels

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Day</th>
<th>Night</th>
<th>0 (Access to night superintendent and/or staff nurse from the hospital complex)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurse in intellectual disability</td>
<td>2</td>
<td>0</td>
<td>Access to night superintendent and/or staff nurse from the hospital complex</td>
</tr>
<tr>
<td>Care Staff</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

The unit was developing an induction programme for new staff. It was reported that clinical supervision and access to training were available to staff. The training records were held centrally in the training department. A copy of the record was not available to the CNM2. Training in the Mental Health Act had not been completed by all staff.

Article 27: Maintenance of Records

The unit did not have a single composite set of notes for each resident. The nursing care plans were separate from the main file and the day centre staff kept their own records. The files were difficult to follow as the residents had a number of volumes of files, all of which were stored on site in a small nursing office. They were large and contained copious amounts of information, which was not organised. There were no written policies and procedures relating to the creation of, access to, or retention and destruction of records.

Article 28: Register of Residents

On the day of the inspection no register was in place. However during the course of the day one was commenced. None of the residents had a Personal Public Service (PPS) number.

Article 29: Operating policies and procedures

There were a number of operational policies needed in order to be compliant with the Regulations.

COMPLIANT YES NO ✔

Article 30: Mental Health Tribunals

At the time of the inspection no patient had been detained under the Mental Health Act 2001.

Article 31: Complaint Procedures

The unit were developing a complaints process in line with the Trust in Care policy. No time frame for this was indicated.

COMPLIANT YES NO ✔

Article 32: Risk Management Procedures

A risk audit was planned but no time frame was available. There was no comprehensive risk management policy in place.

COMPLIANT YES ✔ NO

Article 33: Insurance

The insurance certificate was not viewed on the day of the inspection. It was reported that there was adequate insurance in place.

COMPLIANT YES ✔ NO

Article 34: Certificate of Registration

A certificate of registration was displayed within the unit.

COMPLIANT YES ✔ NO
2.2 EVIDENCE OF COMPLIANCE WITH RULES – MENTAL HEALTH ACT SECTION 52(d)

SECLUSION

Seclusion was actively used within the unit with frequent usage recorded for a number of residents. The unit was staffed at night by care staff only. If seclusion was commenced after 2000h the night superintendent with responsibility for the entire complex had to be called, as care staff cannot commence seclusion orders. There was a seclusion policy, which was under review. There was no written record to show that staff were aware of the Rules regarding seclusion. There were a number of consistent errors in the recording of seclusion:

- A carbon copy of the seclusion register was not placed in the resident’s files. The reason given was that the filing system was under review.
- The medical staff were not making entries in the clinical file following assessment of the resident and commencement of seclusion orders.
- There was no record that information was provided to residents or that their family or next of kin were informed once seclusion orders had commenced. It was reported that the Clinical Director was meeting with families to discuss this.
- It was reported that the speech and language therapist had been asked to develop a visual signing template to assist staff in helping residents to receive and understand information on seclusion as per the Rules.
- The hospital did not have Personal Public Service (PPS) numbers for all of the residents and the social worker had commenced the process of obtaining these. The PPS number is required on the Seclusion Register, which must be completed in the event of seclusion being used.

There was one seclusion room which was located on the main bedroom corridor. It was a single room with cushioned finish on the walls. There were no sanitary facilities in the room. The nearest toilet was two doors away and was designated a female toilet. There was a window with a blind that could be controlled from outside the room. There was a peephole and CCTV camera. The camera monitor was located in a small nursing office. It did not record and its location supported the privacy and dignity of the individual. There was no means of communication from the seclusion room.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

ECT

There were no ECT facilities within the unit or hospital complex. ECT was not offered as a treatment.

MECHANICAL RESTRAINT

It was reported that mechanical restraint was not used on the unit.

2.3 EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001, SECTION 51(1)(b)(iii)

PHYSICAL RESTRAINT

There was no policy on the use of physical restraint. It was reported that the training records were held centrally. There were two members of staff trained as trainers in Crisis Prevention Intervention (CPI) techniques. The clinical practice forms regarding the use of physical restraint were reviewed during the inspection. There were a number of consistent errors in the recording of physical restraint:

- The duplicate sheet was not placed in the patient’s file.
- There was no corresponding record in the clinical file. In some cases physical restraint was commenced in day services or off site and the person who initiated the method did not record the action in the clinical file.
The hospital did not have Personal Public Service (PPS) numbers for all of the residents and the social worker had commenced the process of obtaining these. The PPS number is required on the physical restraint register, which must be completed in the event of physical restraint being used.

The service did have a restraint prescription sheet on each resident that was reviewed at set intervals.

| COMPLIANT | YES | NO | ✓ |

ADMISSION OF CHILDREN

It was reported that the unit policy was not to admit children.

2.4 EVIDENCE OF COMPLIANCE WITH ADMINISTRATION OF MEDICATION – MENTAL HEALTH ACT 2001, SECTION 60

This was not applicable as there were no detained patients in the unit.
1.2 RECOMMENDATIONS ARISING FROM THE 2006 REPORT

1. Policy on cot sides should be developed in line with MHC guidelines.

   **Outcome:** No policy had been developed regarding the use of cot sides.

2. All teams should adhere to the proposed multidisciplinary team care planning procedures and documentation

   **Outcome:** Clinical files were integrated.

1.3 MULTIDISCIPLINARY TEAM FUNCTIONING

There was access to social work by referral. A senior psychologist and a part-time psychologist provided a service to all residents who required psychological intervention. There was one senior occupational therapist and one basic grade occupational therapist. There were two consultant psychiatrists and two-part time psychiatrists.

1.4 MULTIDISCIPLINARY TEAM CARE PLANS

Residents had care plans and these incorporated nursing care plans. Clinical files contained medical, nursing and other professional entries.

1.5 THERAPEUTIC ACTIVITIES

A wide range of therapeutic services and programmes were available both in St. Edmundsbury and in St. Patrick’s Hospital. These included an anxiety management programme, a depression management programme and a discharge group.
1.6 ENVIRONMENT AND FACILITIES

The building was in good condition, well lit and ventilated, and with appropriate furnishing. Some areas had been assessed as having risks for staff and residents. A number of recommendations had been acted upon, such as providing alarms in each room, and personal pinpoint alarms.

1.7 INTERVIEWS WITH RESIDENTS

Residents reported satisfaction with the service.

1.8 GOOD PRACTICE DEVELOPMENTS

1. Approval had been obtained for funding for six high observation beds, although no start date had been decided.

2. A post for a part-time family therapist had been advertised.

3. The part-time cognitive behavioural therapist post had been upgraded to full time.

1.9 2007 RECOMMENDATIONS ON QUALITY OF CARE AND TREATMENT UNDER MENTAL HEALTH ACT 2001 – SECTION 51(1)(b)(i)

1. The outstanding recommendations from 2006 should be completed.

2.1 EVIDENCE OF COMPLIANCE WITH REGULATIONS 2006 – MENTAL HEALTH ACT 2001, SECTION 52(d)

This part of the report was completed using a number of evidence bases: a self-assessment report completed by the service and submitted to the MHC Quality and Standards Division prior to the inspection date, interviews with senior nursing staff, interviews with the Clinical Director and Director of Nursing, and a paper review of all relevant documents on the unit and in the hospital.

Article 4: Identification of Residents

Each resident had a personal identification number, which was used as an identifier.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
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</table>

Article 5: Food and Nutrition

Filtered water was available. A self-service catering system was available with menu choice. Vegetarian options were available.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

Article 6 (1–2): Food Safety

This was not inspected on the day.
**Article 7: Clothing**

Residents had their own clothes. Night clothes were worn during the day only if this was part of the individual resident’s care plan.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

**Article 8: Residents’ Personal Property and Possessions**

There was a policy relating to residents’ property. Residents controlled their own property and each bedroom had a safe.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
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</table>

**Article 9: Recreational Activities**

There was a recreation room with table tennis, exercise equipment and computers.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

**Article 10: Religion**

Provision was made for all religious practices and there was a contact list for different clergy.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

**Article 11 (1–6): Visits**

There was sufficient space for visitors and set times for visiting although flexible arrangements could be made if necessary. A committee had identified risk factors relating to visits and the recommendations were being implemented. The policy stated that all children under 3 years of age must be under adult supervision when visiting. There were policies and procedures in place for visiting.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

**Article 12 (1–4): Communication**

There were no restrictions on visiting, receiving phone calls or letters. Letters were never opened. The service had a policy and procedure for communication.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

**Article 13: Searches**

There was a policy on searching residents and their property. All searches were documented in the clinical record. Residents’ property was searched routinely on admission following consent from residents. In the absence of consent, the consultant authorised a search if necessary. Within the policy, there was provision for two nurses to be present during searches.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

**Article 14 (1–5): Care of the Dying**

A policy on care of the dying was in place and there were also policies available for different religious practices. The policy did not contain the stipulation that the Mental Health Commission be notified of all deaths.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

**Article 15: Individual Care Plan**

Clinical files contained medical and other professional entries and the nursing care plans were incorporated in the MDT care plan.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

**Article 16: Therapeutic Services and Programmes**

A wide range of therapeutic services and programmes were available both in St. Edmundsbury and in St. Patrick’s Hospital. These included an anxiety
management programme, a depression management programme and a discharge group.

<table>
<thead>
<tr>
<th>Article 21: Privacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>There were a number of individual rooms. There were curtains around each bed. Residents were able to lock shower doors.</td>
</tr>
<tr>
<td>COMPLIANT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Article 17: Children’s Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Inspectorate was informed that children were not admitted to St. Edmundsbury.</td>
</tr>
<tr>
<td>COMPLIANT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Article 18: Transfer of Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>There was an internal transfer policy that was used to transfer residents to and from St. Patrick’s Hospital. There was a transfer policy available regarding transfer to other hospitals.</td>
</tr>
<tr>
<td>COMPLIANT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Article 19 (1–2): General Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents had access to a physician and neurologist in St. Patrick’s Hospital. None of the residents were more than six months in hospital. Residents were facilitated in attending screening programmes. A policy and procedure regarding medical emergencies was in place. There was an NCHD on duty at all times in St. Edmundsbury.</td>
</tr>
<tr>
<td>COMPLIANT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Article 20 (1–2): Provision of Information to Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>An information booklet was available for all residents, containing housekeeping arrangements as well as individual information about residents’ multidisciplinary team, medication and diagnosis. Peer advocacy information was displayed on noticeboards.</td>
</tr>
<tr>
<td>COMPLIANT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Article 22: Premises</th>
</tr>
</thead>
<tbody>
<tr>
<td>The building was in good condition, well lit and ventilated, and with appropriate furnishings. Some areas had been assessed as having risks for staff and residents. A number of recommendations had been put into place such as alarms in each room, and personal pinpoint alarms.</td>
</tr>
<tr>
<td>COMPLIANT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Article 23 (1–2): Ordering, Prescribing, Storing and Administration of Medicines</th>
</tr>
</thead>
<tbody>
<tr>
<td>All policies and procedures regarding medication were located in the pharmacy in St. Patrick’s Hospital and were made available in St. Edmundsbury Hospital.</td>
</tr>
<tr>
<td>COMPLIANT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Article 24 (1–2): Health and Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>There was a safety statement that was last revised in 2003.</td>
</tr>
<tr>
<td>COMPLIANT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Article 25: Use of Closed Circuit Television (CCTV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCTV was not used for observation of residents.</td>
</tr>
<tr>
<td>COMPLIANT</td>
</tr>
</tbody>
</table>
Article 26: Staffing

All policies regarding staffing were maintained within the Human Resources department of St. Patrick’s Hospital. The hospital management had a new process in place for Garda vetting. A record of staff on duty was kept.

Table 1: Unit staff levels

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered psychiatric nurse</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Care staff</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

All staff were trained in basic life-saving skills, control and restraint and manual handling. There was no record of individual training. All staff had been trained in the Mental Health Act 2001. There was a copy of the Act, Regulations and Rules available to staff.

Article 27: Maintenance of Records

The service had a written policy on the maintenance of medical records. Documentation was maintained in St. Patrick’s Hospital, not in St. Edmundsbury.

Article 28: Register of Residents

The register of residents was maintained in St. Patrick’s Hospital and did not contain all the information detailed in Schedule 1 of the Regulations.

Article 29: Operating policies and procedures

Review of operating policies and procedures took place every three years.

Article 30: Mental Health Tribunals

Provision for the holding of mental health tribunals had been made.

Article 31: Complaint Procedures

There was a policy and complaints procedure in place that complied with the provisions of Article 31.

Article 32: Risk Management Procedures

Policies covered risk assessment, residents absent without leave, suicide and self harm, assault responding to emergencies and accidental injury. The Trust in Care policy was in place. The quality department in St. Patrick’s Hospital provided analysis and feedback of incidents as well as informing the MHC of serious incidents.

Article 33: Insurance

The insurance cover was organised by St. Patrick’s Hospital. A copy of the insurance cover was not sent to the Inspectorate as requested.

Article 34: Certificate of Registration

The certificate of registration was displayed in St. Patrick’s Hospital.
2.2 EVIDENCE OF COMPLIANCE WITH RULES - MENTAL HEALTH ACT 2001, SECTION 52(d)

SECLUSION

The service reported that seclusion was not used in St. Edmundsbury Hospital.

ECT

The Inspectorate was informed that ECT was not used in St. Edmundsbury Hospital.

MECHANICAL RESTRAINT

The service reported that mechanical restraint was not used in St. Edmundsbury Hospital.

2.3 EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001, SECTION 51(1)(b)(iii)

PHYSICAL RESTRAINT

The Inspectorate was informed that physical restraint was not used in St. Edmundsbury Hospital.

ADMISSION OF CHILDREN

The service reported that children were not admitted to St. Edmundsbury Hospital.

2.4 EVIDENCE OF COMPLIANCE WITH ADMINISTRATION OF MEDICATION – MENTAL HEALTH ACT 2001, SECTION 60

This was not applicable as the hospital did not admit detained patients.
INTRODUCTION

St. John of God Hospital was an approved centre under the Mental Health Act 2001. The purpose of this announced inspection was to comment on the quality of care and treatment given to residents in receipt of mental health services and determine the degree and extent of compliance by the approved centre with the Regulations, Codes of Practice and Rules for Treatment (Sections 50 to 55 and 66, Mental Health Act 2001). The Inspectorate also followed up recommendations from the 2006 report, on multidisciplinary team (MDT) functioning and care planning, and spoke to residents where requested.

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

1.1 DESCRIPTION

St. John of God Hospital provided private in-patient and outpatient mental health care. The service contracted 39 beds to Cluain Mhuire public catchment service. The hospital complex had 183 integrated beds, configured over eight suites (Table 1).

<table>
<thead>
<tr>
<th>Suite</th>
<th>Specialty</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Peter’s</td>
<td>Intensive care</td>
<td>18</td>
</tr>
<tr>
<td>St. Paul’s</td>
<td>General adult</td>
<td>34</td>
</tr>
<tr>
<td>St. Joseph’s</td>
<td>General adult</td>
<td>32</td>
</tr>
<tr>
<td>St. Camillus’s</td>
<td>Alcohol and substance misuse</td>
<td>27</td>
</tr>
<tr>
<td>St. Brigid’s</td>
<td>Eating disorder recovery programme</td>
<td>20</td>
</tr>
<tr>
<td>Carraigfergus</td>
<td>Psychiatry of later life</td>
<td>24</td>
</tr>
<tr>
<td>Carraigdubh</td>
<td>Psychiatry of later life</td>
<td>16</td>
</tr>
<tr>
<td>Ginesa</td>
<td>Child and adolescent</td>
<td>12</td>
</tr>
</tbody>
</table>

1.2 RECOMMENDATIONS ARISING FROM THE 2006 REPORT

Overall Recommendations

1. There should be multidisciplinary care plans on each unit or suite.

Outcome: The Ginesa Suite had introduced multidisciplinary team care planning but this was at an early stage. There were plans to start a pilot project in one of the other suites and extend it throughout the hospital by the end of 2007.

2. The refurbishment of St. Peter’s should proceed with urgency.

Outcome: The building works and complications arising from it had resulted in a delay in the start date for the refurbishment. It was expected by the senior management team that the unit refurbishment would be completed within 18 months.

3. Therapeutic activities programme should be increased in St. Peter’s Unit as a matter of urgency.

Outcome: The range of activities available to residents had been expanded and this is discussed in more detail later in the report under Article 16: therapeutic services and programmes.
1.3 MULTIDISCIPLINARY TEAM FUNCTIONING

There were no sector community mental health teams as St. John of God Hospital offers a nationwide service. Multidisciplinary staffing and functioning reflected this method of service delivery. The management team consisted of the Clinical Director, Director of Nursing and Hospital Manager. Heads of discipline were not included. The hospital delivered sub-specialty programmes as well as acute mental health care. There were three residents on St. Peter’s Suite who had forensic low secure needs and this was demanding extra staffing resources and diverting attention from the other residents on the ward.

1.4 MULTIDISCIPLINARY TEAM CARE PLANS

There was some evidence on Ginesa Suite that a multidisciplinary care plan had been initiated. Individual MDT care plans were not in use in the rest of the hospital. A task group had been set up to research and suggest care plans appropriate for each resident group. This group was due to report by the end of 2007. The hospital had nursing care plans, medical treatment plans and individual discipline care plans.

1.5 THERAPEUTIC ACTIVITIES

Although the service provided a range of therapeutic programmes, these were not linked to an integrated MDT care plan. Psychologists, social workers and occupational therapists provided individual or group therapeutic interventions.

1.6 ENVIRONMENT AND FACILITIES

The premises were maintained to a high standard. Routine cleaning and maintenance was evident throughout the hospital. The furnishings were of a good standard and were appropriate to the needs of the residents. The service had plans for major refurbishment of St. Peter’s Suite and the ECT suite.

1.7 INTERVIEWS WITH RESIDENTS

A number of residents asked to speak to the Inspectorate individually. The main issues raised concerned the outcomes of mental health tribunals. A group of young people in Ginesa Suite also asked to meet with the Inspectorate. The main issues of concern were smoking and inconsistent responses by staff to visiting and phone calls. These issues were discussed further with the clinical nurse manager. The Inspectorate pointed out that staff should be familiar with the unit’s policies and procedures and that special conditions for an individual should be clearly identified in the resident’s respective care and treatment plan.

1.8 GOOD PRACTICE DEVELOPMENTS

1. A national psychosis programme was being developed. The hospital was recruiting for the team at the time of the inspection. It was planned that the team would form links with the existing DETECT programme.

2. A new consultant psychiatrist post for addiction/substance misuse had been filled.

### Table 2: MDT staff levels

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Number (whole-time-equivalent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant psychiatrist</td>
<td>8.5</td>
</tr>
<tr>
<td>Nurse</td>
<td>145.31</td>
</tr>
<tr>
<td>Social worker</td>
<td>36.64</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>7.37</td>
</tr>
<tr>
<td>Clinical psychologist</td>
<td>5.5</td>
</tr>
<tr>
<td>Clinical pharmacist</td>
<td>4</td>
</tr>
<tr>
<td>Others</td>
<td>113.74</td>
</tr>
</tbody>
</table>
3. Plans for the redevelopment and redesign of St. Peter’s and the ECT suite were advanced. This would provide improved facilities for ECT and seclusion. There were long-term plans to build a new hospital complex.

1.9 2007 RECOMMENDATIONS ON THE QUALITY OF CARE AND TREATMENT – MENTAL HEALTH ACT 2001, SECTION 51(1)(b)(i)

1. Multidisciplinary care plans should be introduced for each resident.

2. The management team should be enhanced by including heads of discipline in accordance with national policy.

3. The needs of forensic patients should be addressed within an appropriate environment and treatment setting.

PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE ON 4 APRIL 2008

2.1 EVIDENCE OF COMPLIANCE WITH REGULATIONS 2006 – MENTAL HEALTH ACT 2001, SECTION 52(d)

This part of the report was completed using a number of evidence bases: a self-assessment report completed by the service and submitted to the MHC Quality and Standards Division prior to the inspection date, interviews with the senior management team, CNM3s and CNM2s and other relevant staff, a paper review of all relevant documents relating to the hospital provided on the day, and photographic evidence. Two suites, St. Peter’s and Ginesa, were examined in detail to establish compliance with the Regulations. In addition visits were conducted at Carraigfergus and Carraig Dubh to establish compliance with a number of Codes of Practice.

Article 4: Identification of Residents

St. Peter’s Suite was staffed by a consistent group of nursing staff. Two registered psychiatric nurses, including at all times one nurse from the previous day’s duty, perform the drug round.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

Article 5: Food and Nutrition

There was evidence during the inspection that yearly analysis of the water supply and water dispensers and vending machines was conducted throughout the hospital. On St. Peter’s Suite, a water dispenser in the nurses’ station was accessible to residents. The dining room was shared with St. Paul’s Suite. There were diet sheets available for special diets and a printed set menu every day, with a choice of food available. All food was cooked on site and delivered to the suite in a timely manner. In addition, evening sandwiches and tea were available at 2030h.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

Article 6 (1–2): Food Safety

The hospital had initiated an independent inspection process of food safety. A number of recommendations were made in 2006 and they were being implemented. A copy of this report was provided during the inspection process.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

Article 7: Clothing

In general, each resident brought in their own clothes at admission and next of kin or family brought more if required. A small store of clothes was kept on the ward.
and could be drawn on as needed by a resident. The suite received a monthly petty cash sum in order to buy toiletry supplies for residents who might not have had them on admission and this stock was maintained on the ward. Residents did not wear night clothes during the day. A number of residents in high observation and seclusion were placed in refractory clothing and this was prescribed in their care plan.

### Article 11 (1–6): Visits

A detailed visitors policy was displayed on the entrance door to St. Peter’s Suite. There were reasonable times for families and friends to visit and arrangements could be made for visits outside these times for families travelling from the country. A multipurpose room had been made available at the end of the ward for large groups of visitors to meet residents in private. Children under the age of 14 years were not allowed on the suite. Other visits could take place either in the common room, in the TV area, or in individual bedrooms. All visitors had to report to the staff nurses on duty prior to visiting residents. The policy on visiting commenced on August 2001 and was due for renewal in August 2002. The visitors’ policy needed to be updated to include the procedure regarding visiting of children under the age of 14 years to St. Peter’s Suite. An updated version of this policy dated May 2007 was subsequently sent to the Inspectorate.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

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

The hospital had a policy and procedures regarding residents’ personal property and possessions. It was implemented in August 2005 and had a review date of August 2007. A record book detailed the resident’s property and possessions on admission and was signed by the resident and the nurse and placed in the file. Residents maintained control of their personal property and possessions except in the circumstance where dangerous items were identified. All items removed from residents were kept in individual drawers in the nurses’ station.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

### Article 9: Recreational Activities

There were a number of activities available to the residents during their stay on St. Peter’s Suite. These included walks accompanied by nursing staff, using a DVD player, or watching TV, as well as nurse-run groups at the weekend that provided recreational activity.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

### Article 10: Religion

The Roman Catholic chaplain visited the ward daily. Other religions were facilitated as needed and requested.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

### Article 12 (1–4): Communication

A detailed policy and procedure were in place regarding communication. It was dated August 2005, with a review date in August 2007. Each resident in St. Peter’s Suite had access to mail and phone. There was a public phone on the suite. The communication policy did not contain any procedure regarding examining of incoming and outgoing communication if there was reasonable cause to believe that the communication could result in harm to the resident or others.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

### Article 13: Searches

There was no specific policy relating to searches. It was contained in the policy with the title Patient Personal Property and Possession. The nursing staff on the ward were aware of the procedure regarding conducting searches with consent and without consent. This needed to be documented in a separate policy and maintained.
on the suite. All illicit substances found on the ward were held and recorded by two staff members, sealed and handed over to An Garda Síochána. The approved centre subsequently sent an amended separate policy on searches to the Inspectorate, which included procedures for search with or without consent. This needed to be amended to include a procedure for keeping a written record of searches.

**Article 14 (1–5): Care of the Dying**

The hospital had a detailed policy on the care of the dying, incorporating all aspects of care and treatment. There were also policies relating to expected and unexpected deaths. These policies were dated March 2007 with a review date of March 2009.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES ✅</th>
<th>NO</th>
</tr>
</thead>
</table>

**Article 15: Individual Care Plan**

The hospital had nursing care plans, medical treatment plans and individual discipline care plans. A task group had been set up to research and suggest care plans appropriate for each resident group. This group was due to report by the end of 2007. There was some evidence on Ginesa Suite that a multidisciplinary care plan had been initiated.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES ✅</th>
<th>NO</th>
</tr>
</thead>
</table>

**Article 16: Therapeutic Services and Programmes**

The occupational therapy group programme on St. Peter’s Suite had been expanded since the last inspection. There were now three one-hour sessions a week. The occupational therapy notes were held on the suite in a separate folder. The occupational therapist also attended the ward and team meetings and reviewed referred residents referred to them.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES ✅</th>
<th>NO</th>
</tr>
</thead>
</table>

**Article 17: Children’s Education**

All children were admitted to Ginesa Suite. The Inspectorate was informed that there was a part-time liaison teacher for seven hours every week. The teacher provided two 1.5-hour educational sessions for group or individual school work. Educational input followed the national curriculum and was included in the young person’s care plan at admission. This service was provided by the hospital and there was no involvement by the Department of Education and Science.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES ✅</th>
<th>NO</th>
</tr>
</thead>
</table>

**Article 18: Transfer of Residents**

There was a detailed internal transfer policy on St. Peter’s Suite. The main internal transfers related to children being transferred from Ginesa Suite to St. Peter’s Suite for short periods of intensive observation or seclusion. This generally was a very short length of stay ranging from a matter of hours to overnight. There was no external transfer policy for residents moving from the approved centre to another hospital, or any other place. The approved centre subsequently sent policies to the Inspectorate relating to Referral of a Patient to and from the Central Mental Hospital (issued April 2007), Patient Transfer from One Approved Centre to Another (May 2007) and Patient Transfer from an Approved Centre to a General Hospital (date of issue May 2007).

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES ✅</th>
<th>NO</th>
</tr>
</thead>
</table>

**Article 19 (1–2): General Health**

All St. Peter’s Suite residents had a physical examination completed by the NCHD. During the course of their admission all physical or general health problems were referred to the NCHDs, or where necessary to external
Article 21: Privacy

There were seven double rooms and one room with four beds in St. Peter’s Suite. There was adequate space and there were curtains around each bed area. There were no single rooms in the ward. There were gender-specific toilets and bathroom areas and every effort was maintained to ensure the privacy and dignity of each resident.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
<th>✓</th>
</tr>
</thead>
</table>

Article 22: Premises

St. Peter’s Suite was located on the upper floor of the hospital. It was clean and well maintained. There were cleaners on the ward daily. The premises were lit, heated and ventilated. There was a maintenance department on site. Requests were submitted through a maintenance book and response time was reported to be good. There were plans to redesign the layout and the structure of St. Peter’s Suite to ensure greater privacy, safety and suitability for residents. These were due for completion within 18 months. The ward was accessible by a lift. There was no wheelchair-accessible shower, though this was included in the new plans for the unit.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
<th>✓</th>
</tr>
</thead>
</table>

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

The resident information booklet available on St. Peter’s Suite was being updated. It included the resident’s name and the name of the consultant psychiatrist, registrar, clinical nurse manager, primary nurse and associate nurse involved. It detailed the philosophy of the ward and various housekeeping arrangements. The leaflet was being updated to include the provisions necessary under Article 20 of the Mental Health Act 2001. The Irish Advocacy Network visited weekly or more often as required and AA meetings were facilitated throughout the hospital. The pharmacy provided written information regarding medications and side effects when requested by the resident. Verbal information on medication was given by all staff when requested by the resident and as part of the team meeting. The service had policy and procedures with the title Provision of Information for Patients (residents) dated November 2006. The Inspectorate was given a copy of an information booklet about Ginesa Suite for young people and carers. This included information about the purpose of the unit, acceptable and unacceptable behaviour and other housekeeping arrangements. Some of the young people interviewed said that they had not received a copy of this.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>✓</th>
<th>NO</th>
</tr>
</thead>
</table>

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

The hospital had a detailed written policy document in place on the order and storing of medicines implemented on 25 February 2003 with a review date in 2007.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>✓</th>
<th>NO</th>
</tr>
</thead>
</table>
Article 24 (1-2): Health and Safety

St. John of God Hospital had a detailed health and safety statement dated November 2005. Each new member of staff received a shortened version as part of the induction process.

| COMPLIANT | YES ✔ | NO |

Article 25: Use of Closed Circuit Television (CCTV)

There was a detailed policy in place outlining the use of CCTV on the ward areas and in the non-ward areas. CCTV in the non-ward areas was capable of recording but was not used to monitor residents. CCTV in use in ward areas was not capable of recording. CCTV was only used in wards where observation was necessary. There were adequate notices on all of the walls detailing that CCTV was in use and there was a policy in place. In Ginesa Suite there were nine CCTV cameras, covering all public areas in the unit. There were notices in the unit about the use of CCTV and details were also included in the information booklet.

| COMPLIANT | YES ✔ | NO |

Article 26: Staffing

St. John of God Hospital had a detailed human resource policy regarding recruitment, selection and vetting of staff. There were twelve policies in place, including policies concerning diversity, disability and the recruitment process. On St. Peter’s Suite all nursing staff were registered psychiatric nurses.

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered psychiatric nurse</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>

On the day of the inspection there were six registered psychiatric nurses, one CNM1 and one CNM2 on duty. At night there were five registered psychiatric nurses. The clinical nurse manager in charge of the unit rostered all staff. It was reported to the Inspectorate by the senior management team that current staffing levels were appropriate for the skill mix, needs of residents, size and layout of the approved centre. There were three residents on the St. Peter’s Suite who had forensic low secure needs and this was demanding extra staffing resources. There was always a suitably qualified staff member on duty. At night time, there was an Assistant Director of Nursing on duty. During the day, the clinical nurse manager had access to other senior nurses, Assistant Directors of Nursing and the Director of Nursing. The clinical nurse manager on St. Peter’s Suite was able to show that each staff member had received induction training and training in cardio-pulmonary resuscitation (CPR), control and restraint, and Crisis Prevention Intervention (CPI) techniques. All training records were held on the ward and signed off. All staff had also completed training regarding the Mental Health Act 2001. A copy of the Act, Codes of Practice and Rules for Treatment were available on the ward as well as a reference guide. There were also detailed files provided for the admission procedure of a detained patient. The Regulations were not available on the ward.

| COMPLIANT | YES ✔ | NO |

Article 27: Maintenance of Records

There were detailed written policies and procedures in place relating to the creation of, access to, and retention and destruction of records. The medical records department maintained all records. Some of the residents’ records were written on unheaded paper and some records were not signed or dated correctly.

| COMPLIANT | YES ✔ | NO |

Article 28: Register of Residents

Information was held centrally on a computerised system. Senior management reported that the details required on admission included those on Schedule 1 of the Regulations.
Article 29: Operating policies and procedures

St. John of God Hospital had detailed policies and procedures. They were all dated and signed and included a review date within three years on their implementation.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>✓</th>
<th>NO</th>
</tr>
</thead>
</table>

Article 30: Mental Health Tribunals

St. John of God Hospital had facilities available for holding of mental health tribunals. In addition, a part-time consultant psychiatrist had been appointed to cover the consultant psychiatrist who attended tribunals. The resident’s primary nurse was available to attend the tribunal.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>✓</th>
<th>NO</th>
</tr>
</thead>
</table>

Article 31: Complaint Procedures

The complaints policy was dated 2004 and outlined the complaints procedure. The complaints procedure was also displayed on the board. There was a complaint form available. The policy referenced the Mental Treatment Act, 1945, and required updating. The policy stated that all complainants will receive a reply in writing within five days. A record of complaints was maintained and it was reviewed by the Inspectorate during the inspection process.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>✓</th>
<th>NO</th>
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</table>

Article 32: Risk Management Procedures

There was a detailed, comprehensive risk management policy in place that applied throughout the whole hospital. On St. Peter’s Suite, a number of risks had been identified and they had been corrected since the last inspection. They included collapsible shower rail curtains on the wards. Other risks had been identified and the Inspectorate was informed that these would be rectified during the redecoration and redesign of St. Peter’s Suite. There were policies in place to identify specified risks under the Regulations, including residents’ absence without leave, suicide and self-harm, assault, and accidental injuries to residents and staff. There was a new incident reporting system in place and there were plans to employ a Risk Manager in the near future. There were detailed arrangements for responding to emergencies at different levels. The clinical nurse manager in St. Peter’s Suite carried a bleeper and there was a receiver on each of the other wards. Arrangements for the protection of vulnerable adults from abuse were dealt with at local level through nurse management structures.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>✓</th>
<th>NO</th>
</tr>
</thead>
</table>

Article 33: Insurance

The Inspectorate was made aware of the insurance schedule for St. John of God Hospital.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>✓</th>
<th>NO</th>
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</thead>
</table>

Article 34: Certificate of Registration

The Certificate of Registration was prominently displayed in the main entrance hall to St. John of God Hospital.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>✓</th>
<th>NO</th>
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</thead>
</table>

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

SECLUSION

Seclusion was used only on St. Peter’s Suite. There was a dedicated seclusion room. There were means of communication for the patient, access to a nearby toilet, ventilation and light control. There were no deficits in safety. The seclusion register was up to date and evidence of regular reviews of patients in seclusion was available. The design and decor of the seclusion room and area were...
not of good standard. The Inspectorate was shown plans for refurbishment, which would include a new seclusion suite.

| COMPLIANT | YES | NO | ✓ |

ECT

The ECT suite was located on St. Paul’s Suite. There was no waiting area but an office was used as an interim waiting area until the refurbishment of the ECT suite took place. The current ECT treatment room and recovery room were of adequate size. However the ECT machine was due to be replaced before November 2006. A new ECT machine had been ordered that would comply with the Rules on ECT. All other equipment was available. An ECT nurse had recently been appointed and arrangements were being made to train an anaesthetic assistant and there was a dedicated ECT consultant.

| COMPLIANT | YES | ✓ | NO |

MECHANICAL RESTRAINT

The service reported that mechanical restraint was not used within the hospital. Two of the psychiatry of later life wards, Carragelfergus and Carraig Dubh, were visited during the inspection. There was no evidence that mechanical restraint was being used on either ward. There was no evidence either of the use of mechanical restraint for enduring self-harm behaviour.

| COMPLIANT | YES | ✓ | NO |

2.3 EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001, SECTION 51(1)(b)(iii)

PHYSICAL RESTRAINT

The recording of physical restraint was inspected on St. Peter’s Suite. The Inspectorate was satisfied that all aspects of the Code of Practice were met. The hospital had a written policy and all staff received training in relation to physical restraint. Training records were kept by the ward manager.

| COMPLIANT | YES | ✓ | NO |

ADMISSION OF CHILDREN

Ginesa Suite was a specific ward for the admission of children. It had 12 beds and was situated on the first floor of the hospital. The unit had policies and procedures in relation to the admission of children. There was a daily programme of activities provided for the young people and age-appropriate facilities. Entry to the unit was controlled through an intercom system, which required staff to open the door. Young people were not allowed off the unit unaccompanied. Regular meetings were held between young people and staff to discuss issues and concerns. The young people interviewed referred to these meetings.

The relevant acts and guidelines about children were available on the unit and staff have received training in these. There was a system of peer education for staff on the unit. The unit management had reviewed a number of age-appropriate advocacy packages from abroad and was planning to work on one to make it more culturally appropriate to an Irish context. There was a school liaison teacher to facilitate educational provision. There was a booklet for young people that explained the unit and detailed some of their rights.

The unit had a policy stating that all young people should have a risk assessment. The unit had risk assessment forms. There were visiting arrangements in place. The unit had policies on consent and confidentiality. There was no policy on family liaison on the day of the inspection. The approved centre subsequently sent a copy of their Social Work Ginesa policy, which was issued in May 2007, to the Inspectorate and this outlined family liaison policy and protocols.

There had been no involuntary admissions to the unit since the commencement of the Mental Health Act 2001. The unit had a policy about parental consent for treatment of young people who were admitted on a voluntary basis.

| COMPLIANT | YES | ✓ | NO |
ST. PATRICK’S HOSPITAL

Table 1: Configuration of wards

<table>
<thead>
<tr>
<th>Name of ward</th>
<th>Specialty</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dean Swift</td>
<td>Intensive care</td>
<td>31</td>
</tr>
<tr>
<td>Stella</td>
<td>Female admission</td>
<td>31</td>
</tr>
<tr>
<td>Grattan</td>
<td>General adult</td>
<td>42</td>
</tr>
<tr>
<td>Delaney</td>
<td>General adult</td>
<td>32</td>
</tr>
<tr>
<td>Laracor</td>
<td>Alcohol and substance misuse</td>
<td>38</td>
</tr>
<tr>
<td>Kilroot</td>
<td>Male admission</td>
<td>31</td>
</tr>
<tr>
<td>Vanessa</td>
<td>Female</td>
<td>33</td>
</tr>
</tbody>
</table>

INTRODUCTION

St. Patrick’s Hospital was an approved centre under the Mental Health Act 2001. The purpose of this announced inspection was to comment on the quality of care and treatment given to residents in receipt of mental health services and determine the degree and extent of compliance by the approved centre with the Regulations, Codes of Practice and Rules for Treatment (Sections 50 to 55 and 66, Mental Health Act 2001). The Inspectorate also followed up recommendations from the 2006 report, on multidisciplinary (MDT) functioning and care planning, and spoke to residents where requested.

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

1.1 DESCRIPTION

St. Patrick’s Hospital in Dublin provided private mental health care for service users throughout the country. There were 13 consultant psychiatrists with admitting rights to the hospital. There were six admission wards as well as the Dean Swift acute admission ward that incorporated a special care unit. Children were admitted to named single-gender adult wards.

1.2 RECOMMENDATIONS ARISING FROM THE 2006 REPORT

1. All teams should be fully staffed and function as multidisciplinary teams.

   Outcome: There were 13 teams in the hospital complex that had admitting rights to each of the wards, each led by a consultant psychiatrist. Each team functioned differently and the health and social care professionals rarely attended team meetings. There was no evidence in the files reviewed of any entries from these professionals.

2. Mandatory nursing of new admissions in their night clothes should be reviewed and individualised policy should be introduced and based on individual risk assessment.

   Outcome: There was evidence that residents who required nursing in night clothes had this documented in their care plan. There was a hospital policy detailing the responsibility of the medical practitioner and nursing staff in this regard.

1.3 MULTIDISCIPLINARY TEAM FUNCTIONING

Each of the consultant psychiatrists had a specialist interest in a particular area. The health and social care...
professionals were shared between teams and did not attend team meetings regularly and, as stated above, there was little evidence in the files examined of entries from these staff. The nursing staff were ward-based and linked to named consultant psychiatrists. There were weekly medical and nursing reviews of residents on the wards. The Inspectorate observed that in one ward nursing staff were unaware of which programmes residents were attending and were unaware of the location of the residents from the unit. There was no access to an independent peer advocacy service within the hospital but there was a service user council.

**Table 2: MDT staffing levels**

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Number (whole-time-equivalent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant psychiatrist</td>
<td>13</td>
</tr>
<tr>
<td>Nurse</td>
<td>Not submitted</td>
</tr>
<tr>
<td>Social worker</td>
<td>4.5</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>6.5</td>
</tr>
<tr>
<td>Clinical psychologist</td>
<td>5</td>
</tr>
<tr>
<td>Clinical pharmacist</td>
<td>Not submitted</td>
</tr>
<tr>
<td>Psychotherapist</td>
<td>18</td>
</tr>
</tbody>
</table>

1.4 MULTIDISCIPLINARY TEAM CARE PLANS

There were individual MDT care plan forms in use in the hospital. They contained nursing and medical care plans. These were up to date and reviewed regularly at ward rounds. On some of the wards, the multidisciplinary team sheets in the files were blank.

1.5 THERAPEUTIC ACTIVITIES

Residents could be referred to specific treatment programmes, e.g. eating disorder, alcohol treatment, anxiety management, bipolar disorder. The occupational therapists also provided ward-based activities. Referrals could be made to psychology and social work for a range of therapeutic interventions.

1.6 ENVIRONMENT AND FACILITIES

The hospital had a programme of regular maintenance and upgrading. Bathroom and bedroom facilities and furnishing had also been upgraded as a result of health and safety audits. The wards were generally well lit, with good ventilation, and were decorated and maintained to a high standard. There was access to a number of enclosed gardens from some of the wards. These gardens were well maintained. There was a range of furnishings for mobile and mobility-restricted residents and the premises were accessible to people with disabilities.

1.7 INTERVIEWS WITH RESIDENTS

A number of residents asked to speak to the Inspectorate individually. They were generally satisfied with their care and treatment in the hospital but had specific queries about care issues, which were subsequently addressed with the clinical nurse manager.

1.8 GOOD PRACTICE DEVELOPMENTS

1. There were plans to recruit a consultant psychiatrist for child and adolescent services. The Board of Management had approved building plans for the provision of an 11-bed unit for this age group.

1.9 2007 RECOMMENDATIONS ON THE QUALITY AND CARE OF TREATMENT – MENTAL HEALTH ACT 2001, SECTION 51(1)(b)(i)

1. Each resident should have an individual MDT care and treatment plan.

2. All disciplines should record interventions in the resident’s file at regular and timely intervals.
3. Attendance at therapeutic programmes should be linked to the individual care plan and nursing staff should be aware of each resident’s plan and the location of residents.

4. There should be a consistent approach to MDT functioning across all the wards.

5. Peer advocacy services should be developed within the hospital.

### PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE ON 18 AND 24 APRIL 2007

#### 2.1 EVIDENCE OF COMPLIANCE WITH REGULATIONS 2006 – MENTAL HEALTH ACT 2001, SECTION 52(d)

This part of the report was completed using a number of evidence bases: a self-assessment report completed by the service and submitted to the MHC Quality and Standards Division prior to the inspection date, interviews with the CNM2 at ward level, interviews with the Clinical Director, Director of Quality and Director of Nursing, and a paper review of all relevant documents on the wards and in the hospital.

#### Article 4: Identification of Residents

Dean Swift Unit had a consistent group of nursing staff who were familiar with residents. The unit had a policy that two registered psychiatric nurses performed the drug round and this was observed by the Inspectorate. On the other wards, residents were identified using the ward bed plan. There were plans to introduce a resident identifier for the administration of medication.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
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#### Article 5: Food and Nutrition

There was drinking water available on the main unit and in the special care unit. Residents in the special care unit had to request water from nursing staff. Residents who met with the Inspectorate reported no difficulties in accessing water as required. There was a choice of three main-course meals at dinner time. The menu for the week was displayed in the dining area at the beginning of the week and residents chose what they wanted from this. Choices were also available for breakfast and evening meal. The Inspectorate was furnished with a copy of the weekly menu. Nursing staff informed the kitchen of special dietary requirements. There was provision for residents’ religious dietary requirements to be catered for and this was included in their respective care plans. Residents interviewed by the Inspectorate indicated that they were generally satisfied with the food and access to snacks between meals.

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<tr>
<th>COMPLIANT</th>
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#### Article 6 (1–2): Food Safety

This was not inspected on the day.

#### Article 7: Clothing

In general, residents brought their own clothes on admission and these could be supplemented by next of kin or family if necessary. A small store of clothes was kept on the ward and could be drawn on as needed by a resident. Some residents in Dean Swift Unit wore night clothes during the day and this was recorded in their care plan. In the special care unit it was policy that all residents wore night clothes. The policy stated that the wearing of night clothes must be incorporated into care plans.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
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Article 8: Residents’ Personal Property and Possessions

The unit had a policy entitled Processing Patient’s Property. This was issued in January 2007 and due to be revised in January 2008. In addition, a policy about Patients’ Access to Their Clothing was issued in October 2006 and was due for revision in October 2007. Property forms were filed in residents’ files separate from their care plan and a copy given to the resident. Residents had access to personal lockers and wardrobes and were allowed to retain control over their personal belongings, except under circumstances where this posed a danger. Wardrobes were locked by nursing staff if this was requested by the resident. There were facilities for the safe storage of valuables. Residents interviewed reported no difficulties in relation to the security of property and possessions.

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<tr>
<th>COMPLIANT</th>
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<th>NO</th>
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Article 9: Recreational Activities

A TV and board games were available and most residents had their own radios. There was access to an enclosed garden, lounge areas and a smoking room. Residents who were permitted off the unit could also access a number of daily activities in the hospital, e.g. gym, daily lectures, art, and music.

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<th>COMPLIANT</th>
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Article 10: Religion

A Roman Catholic priest visited the hospital every day and there was mass daily. The Roman Catholic priest and a Church of Ireland minister were available to visit specific residents on request. The hospital had a multi-denominational/ecumenical church. Staff reported that there had been no admissions of other religious denominations to Dean Swift Unit since 1 November 2006. The hospital had excellent policies in relation to residents’ spiritual/religious care and provided a list of contact numbers for differing religious services and facilitators on each ward.

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<tr>
<th>COMPLIANT</th>
<th>YES</th>
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Article 11 (1–6): Visits

There was a sign displaying visiting times on the door into Dean Swift Unit and details were also included in information booklets given to residents and relatives. Visiting times were from 1400h to 1630h and 1800h to 2030h. However these times were flexible, except during meal times and after 2230h. There were a number of areas designated for visiting including bedrooms, lounge areas, garden and the coffee shop. The meeting room on the unit was used when children were visiting. The hospital had policies and procedures in relation to Patient Visitor Control issued in October 2006 and due for revision in October 2007. This policy included issues covering the safety of residents, visitors and staff. The Dean Swift unit was locked for the safety of residents.

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<tr>
<th>COMPLIANT</th>
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<th>NO</th>
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Article 12 (1–4): Communication

Residents had access to post and telephones. Email, internet and fax were accessible to those permitted to leave the unit. Most residents also had access to personal mobile phones except where indicated in their care plan. Residents in the special care unit were not allowed access to mobile phones. These facilities were clearly outlined in the information booklet given to residents on admission. In order to be compliant with this Article, this information must be included in a hospital policy, which must also include reference to situations where incoming or outgoing mail is examined as required by regulation.

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<tr>
<th>COMPLIANT</th>
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Article 13: Searches

A policy on Patient Searches was issued in August 2003 and was due for revision in August 2004. This policy outlined procedures to ensure the resident’s dignity and privacy during searches. The policy included provision for situations when residents did not consent to searches. Staff on duty on Dean Swift ward were aware of the policy and procedures in relation to searches. It was not explicit in the policy that consent was sought prior to searches although the policy required that residents understand the policy prior to a search being conducted. The policy indicated that only one staff member was required to be present for searches on Dean Swift ward, except in cases where there was suspicion of theft or possession of items of harm where two staff were required. The Article requires a minimum of two qualified staff to be present during all searches. The policy did not include provision for residents to be informed about what was happening and why, although staff reported that this occurred in practice and residents interviewed concurred with this. There were no written records available on the wards of completed searches. Since the inspection, the approved centre reported in writing that it had implemented a log on the special care unit and that all other searches were reported on the hospital incident form. A written policy on the finding of illicit substances was not available on the day. However, information on this was included in the information booklet given to residents on admission. Following the inspection a policy was submitted to the Inspectorate.

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<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
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<td>YES</td>
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Article 14 (1–5): Care of the Dying

The hospital did not have a policy in relation to care of the dying as required by the Article. There was a Death of a Patient policy and the Patient’s Spiritual/Religious Care policy. The Death of a Patient policy required updating to indicate the legal requirements under the Mental Health Act 2001 to inform the Mental Health Commission in writing of the death of any resident in an approved centre no later than 48 hours of the death occurring.

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<tr>
<th>COMPLIANT</th>
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Article 15: Individual Care Plan

Multidisciplinary individual care plan forms were filed in the files reviewed on Dean Swift ward. These contained only nursing and medical care plans, which were up to date and were reviewed regularly at ward rounds that took place on the unit. Residents could be referred to psychology and social work and to specific treatment programmes in the hospital. The files reviewed on other wards on the second day of the inspection contained only medical and nursing reviews. The interdisciplinary team sheets were blank. There were no entries from health and social care professionals in the files.

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<tr>
<th>COMPLIANT</th>
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Article 16: Therapeutic Services and Programmes

There was an occupational therapist in Dean Swift ward three times a week, providing therapeutic programmes, including art and pottery. Residents could also be referred to specific treatment programmes, e.g. eating disorder, alcohol treatment, anxiety management, or bipolar disorder. There was access to a gym with exercise machines and table tennis. In the other wards inspected, the nursing staff were unaware of the programmes residents were attending. There were no entries from health and social care professionals. There were some typed inserts from clinical nurse specialists dedicated to various programmes. It was difficult to establish a clear link between the care plan and programmes attended.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>YES</td>
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</table>

Article 17: Children’s Education

The hospital had admitted children to two identified single-gender adult wards. There were no structured educational programmes provided. The approved centre had procedures for the admission of children to the hospital, dated 1 May 2007. It stated that the child could have access to appropriate education when the MDT recommended it.

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<thead>
<tr>
<th>COMPLIANT</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>YES</td>
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</table>

Mental Health Commission Annual Report 2007 | 63
Article 18: Transfer of Residents

The service had a number of policies in relation to the transfer of residents. These were: Discharge of a Patient to Another Healthcare Facility, Patient Internal Transfers and Patient Escorts. These policies clearly designated roles and responsibilities for the gathering, writing and transfer of medical and nursing information with the resident.

<table>
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<tr>
<th>COMPLIANT</th>
<th>YES  ✓</th>
<th>NO</th>
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</table>

Article 19 (1–2): General Health

Residents routinely visited general hospitals and external consultant appointments as required. The clinical files examined indicated that residents had up-to-date medical examinations. The service had a Medical Emergency Response policy, issued August 2003 and due for revision in August 2004, and a Checking of Medical Emergency Response Trolley policy, issued October 2006 and due for revision October 2007.

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<tr>
<th>COMPLIANT</th>
<th>YES  ✓</th>
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Article 20 (1–2): Provision of Information to Residents

Staff reported that residents were aware of their MDT from the time of admission. Residents who were interviewed were aware of the names and disciplines of staff involved in their treatment. Residents were provided with an information booklet on admission, which outlined arrangements for personal property, meal times, visiting times and visiting arrangements. Housekeeping arrangements were not mentioned. Information about diagnosis was discussed with residents by nursing staff, consultants and registrars. Information was available in the Patient Information Centre and the Patient Library. Residents who were interviewed informed the Inspectorate that they had accessed this information through these sources. There was no advocacy or voluntary agency information displayed on the unit on the day of the inspection. Staff reported that there was no advocacy involvement on Dean Swift ward or any other unit in the hospital. Since the inspection, the hospital had applied to become a member of the Irish Advocacy Network for adults and Barnardos in relation to age-appropriate services for children. The hospital reported that as an interim measure the contact details for the Irish Advocacy Network had been displayed on the noticeboards in the wards and in the therapy area. Staff and residents reported that medication was usually discussed with residents but that information on possible side effects was not routinely given unless requested. The hospital management reported that information is routinely provided, except in cases where the treating physician deems it inappropriate.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES  ✓</th>
<th>NO</th>
</tr>
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</table>

Article 21: Privacy

In Dean Swift Unit there were four 3-bed bays and the remainder of the rooms were single. The beds in the bays had individual curtains. There were observation panels in all doors allowing direct observation. There were segregated male and female bedroom areas, toilets and showers. In the special care unit it was possible to restrict access to the male or female areas.

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>YES  ✓</th>
<th>NO</th>
</tr>
</thead>
</table>

Article 22: Premises

Dean Swift ward was located on the ground floor of the hospital. It was clean, well maintained and in good decorative condition. Staff reported that the building was about six years old and had had regular maintenance and upgrading over that time. Bathroom and bedroom facilities and furnishing had been upgraded periodically as a result of health and safety audits. There were numerous windows in the unit and in bedrooms for light and ventilation. However, some of the male bay areas in particular were dark. There was access to two separate enclosed gardens from the main ward and the special care unit respectively. These gardens were well maintained. There was a range of furnishings for mobile and mobility-restricted residents and the premise was
accessible to people with disabilities. The premises were of a high standard throughout the hospital complex.

| Article 23 (1–2): Ordering, Prescribing, Storing and Administration of Medicines |
| COMPLIANT  | YES ✔ | NO |

The hospital had a policy on Prescribing/Ordering and Administration of Medication. This was issued August 2003 with no date for review indicated. The policy did not include storage of medication. Since the inspection, the approved centre submitted policies on the management of controlled substances, storage of drug products in the fridge and medication availability outside of hours.

| Article 24 (1–2): Health and Safety |
| COMPLIANT  | YES ✔ | NO |

The hospital had an up-to-date health and safety statement. In addition, numerous other policies included reference to the safety of all persons on the premises.

| Article 25: Use of Closed Circuit Television (CCTV) |
| COMPLIANT  | YES ✔ | NO |

CCTV was not used internally in the hospital to monitor residents. There was CCTV externally to monitor car parks.

| Article 26: Staffing |
| COMPLIANT  | YES ✔ | NO |

The hospital did not have written policies and procedures in relation to the vetting of staff. Approval to seek Garda vetting of staff was received in December 2006. The hospital management had been prioritising staff working with children to receive vetting. Since December 2006 all new employees had vetting. The hospital reported, since the inspection, that it had a self-declaration form for all staff employed. Facilitated discussions had taken place with the trade unions regarding vetting for staff employed prior to December 2006. There was a training programme and policy on education of staff. All staff had received a one-day training course in the Mental Health Act. A copy of the Mental Health Act 2001 was available in the Dean Swift Unit. On the units admitting children, the Code of Practice in relation to children and the Regulations were not available for inspection. The hospital reported that since the inspection, a copy of the Code of Practice in relation to children had been issued to each ward.

| Article 27: Maintenance of Records |
| COMPLIANT  | YES ✔ | NO |

Records of residents on the unit were kept in the locked nurses’ station. The hospital had policies about the creation of, access to, and retention and destruction of records, which included Accessing and Tracking of St. Patrick’s Patients Medical Records, Access to Clinical Information, Order of Medical Record Content, and Confidentiality: Release of Patient Care Information. The Inspectorate was furnished with up-to-date records relating to food safety, health and safety and fire inspections.

| Article 28: Register of Residents |
| COMPLIANT  | YES ✔ | NO |

The register of residents was incomplete and did not meet the requirements of Schedule 1 of the Regulations.

| Article 29: Operating policies and procedures |
| COMPLIANT  | YES ✔ | NO |

The hospital’s quality department was putting in place a mechanism for regular review and updating of policies and procedures. This must be implemented to ensure that all policies are reviewed at least within 3 years. The hospital reported that all policies were reviewed in 2006.
Article 30: Mental Health Tribunals

There was a dedicated area within the hospital to facilitate mental health tribunals.

| COMPLIANT | YES | ✓ | NO |

Article 31: Complaint Procedures

The hospital had a policy with the title Patient/Family/Staff Feedback/Complaints. This policy was issued in December 2006 and due for revision in December 2007. The procedure was outlined in the information booklet given to residents at admission and complaint and comment boxes were located on the unit. Complaints were initially sent to the Quality Management department and then directed to the department head concerned, as appropriate.

| COMPLIANT | YES | ✓ | NO |

Article 32: Risk Management Procedures

The hospital had a health and safety statement and numerous other policies that related to risk management, e.g. Adverse Incident Reporting, Root Cause Analysis. There were yearly health and safety audits, which resulted in changes to the environment on the basis of risk assessment.

| COMPLIANT | YES | ✓ | NO |

Article 33: Insurance

This was not inspected on the day. A copy of insurance documentation was sent to the Inspectorate.

| COMPLIANT | YES | ✓ | NO |

Article 34: Certificate of Registration

The certificate of approval was framed and on display in the main entrance area.

| COMPLIANT | YES | ✓ | NO |

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

SECLUSION

The service reported that seclusion was not used in the hospital.

ECT

The ECT suite was located on the ground floor of the hospital. The facilities, equipment, staffing and training were satisfactory. The ECT service is ECTAS accredited. The Mental Health Commission Rules S59 (2) relating to consent, absence of consent, information and administration of ECT were all complied with. ECT had not been administered during pregnancy in this facility. Case notes were reviewed of patients who had either consented or not consented to ECT. The ECT documentation was satisfactory and easily retrieved. The ECT register completed for the patient on conclusion of a programme of ECT had been completed but was not available on the day of the inspection.

| COMPLIANT | YES | ✓ | NO |

MECHANICAL RESTRAINT

The hospital had a policy prohibiting the use of mechanical restraint for any reason. Staff reported that mechanical restraint was not used.
2.3 EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001, SECTION 51(1)(b)(iii)

PHYSICAL RESTRAINT

Physical restraint was occasionally used in the special care unit. Case files were examined and all contained the clinical practice forms for physical restraint, which had been satisfactorily completed and signed by the consultant psychiatrist. The clinical file progress notes also reflected the use of physical restraint when it had been used. There was a written policy with the title Person-to-Person Physical Restraint, which covered criteria, protocol, training, prohibited practices, discontinuation of restraint, administration of medication and post-incident management.

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ADMISSION OF CHILDREN

St. Patrick’s Hospital admitted children to specified single-gender general adult wards. There were two children in the hospital on 24 April 2007, both of them Voluntary admissions. The Mental Health Commission had been notified using the clinical practice form. Copies of the forms were in the individual care files. All children admitted to the hospital were under the care of a general adult consultant psychiatrist. An external child and adolescent psychiatrist provided expertise as required. The hospital stated that it had policies and procedures in place relating to the admission of children. They were not available on the wards. The young people attended the young adult programme or the eating disorder programme, or both. They were accompanied to and from all groups. All young people were accommodated in single rooms. The nursing staff on the wards reported that it was difficult to respond to the needs of the young person in an adult setting.

The hospital was unable to provide evidence that it was meeting its requirements under the code in relation to

- Garda Síochána or other police vetting
- age-appropriate advocacy services
- staff training relating to the care of children
- provision of policies with regard to family liaison, parental consent and confidentiality.

The senior management team reported that there were plans to develop an 11-bed in-patient unit and to recruit a child and adolescent consultant psychiatrist. Garda vetting had commenced in December 2006 and staff working with children had been prioritised. It was reported that staff training workshops had commenced. External people facilitated them with expertise in the area of children.

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