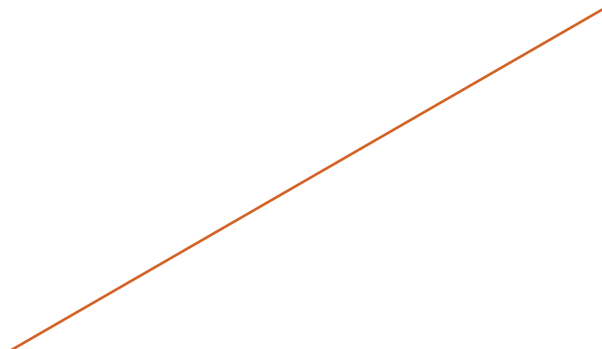
Mental Health Commission

Report of the Targeted Intervention by the Office of Inspector of Mental Health Services, Mental Health Commission into the Carlow/Kilkenny/South Tipperary Mental Health Services

WORKING TOGETHER
FOR QUALITY MENTAL
HEALTH SERVICES



MHC
Coimisiún Meabhair-Shláinte
Mental Health Commission

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ABOUT THE MENTAL HEALTH COMMISSION

The Mental Health Commission is responsible for regulating and monitoring mental health services in Ireland as defined by the Mental Health Act 2001.

The Commission was established in April 2002. We are an independent statutory body and our functions are set out by the provisions of the Mental Health Act 2001. Our main functions are to promote, encourage and foster high standards and good practices in the delivery of mental health services and to protect the interests of patients who are involuntarily admitted and detained *(Section 33(1), Mental Health Act 2001).*

The Commission's remit includes the broad spectrum of mental health services namely general adult mental health services, as well as mental health services for children and adolescents, older people, people with intellectual disabilities and forensic mental health services.

The Mental Health Act 2001 also outlines the additional responsibilities of the Commission. These include:

1. Appointing persons to mental health tribunals to review the detention of involuntary patients and appointing a legal representative for each patient;

2. Establishing and maintaining a Register of Approved Centres i.e. we register inpatient facilities providing care and treatment for people with a mental illness or mental disorder.

3. Making Rules regulating the use of specific treatments and interventions i.e. ECT (Electro-convulsive Therapy), seclusion and mechanical restraint; and

4. Developing Codes of Practice to guide people working in the mental health services.

OUR VISION

Working together for quality mental health services

We will continue to work collaboratively with our stakeholders to create this shared vision and deliver real change in our mental health services. We will continue the alignment of strategies and processes in the mental health domain with the aim of achieving quality mental health services

OUR MISSION

Our Mission is to safeguard the rights of service users, to encourage continuous quality improvement, and to report independently on the quality and safety of mental health services in Ireland

OUR VALUES

The Commission is committed to operating in a manner that demonstrates our core values.

Accountability and Integrity

We will operate at all times in a fair and transparent manner and take responsibility for our actions.

Dignity and Respect

We will show dignity and respect for those using services and those providing them.

Confidentiality

We will handle confidential and personal information with the highest level of professionalism and we will take due care not to disclose information outside of the course of that required by law.

Empowerment

Our goal is to empower sta keholders (service users, families, carers, service providers and general public) through our work.

Quality

We aim to provide a quality service to all our stakeholders through use of evidence informed practices and by adopting a responsive regulatory approach.

Achieving Together

Our work will be at all times oriented towards recovery, encouraging and focusing on strong, equal partnerships between service users, families and carers and service providers.

PART 1: INTRODUCTION

This report presents the findings, recommendations and subsequent implementation of the recommendations by the Health Service Executive (HSE) in relation to a Targeted Intervention Quality Improvement initiative undertaken by the Mental Health Commission (the Commission or MHC) through the Office of the Inspector of Mental Health Service in Carlow/Kilkenny and South Tipperary Mental Health Services.

The impetus for this report arises partly from a number of deaths in the region referred to in the report. The Commission offers its condolences to the bereaved families for whom this report may bring back strong feelings of grief.

On 21 March 2014 the Commission instructed the Chief Executive to request the Inspector of Mental Health Services (the Inspector) to carry out a review of service user safety culture and governance in Carlow/Kilkenny Mental Health Services. This review was prompted by Commission concerns regarding service user safety and clinical governance.

Clinical governance may be perceived as 'management speak' therefore it is imperative that there is a general understanding that it refers to governance for quality and safety of healthcare provision.

Following discussion with the HSE regarding concerns in relation to governance, the Area manager commissioned a review of the clinical governance structures within Carlow/Kilkenny and South Tipperary mental health services culminating in a Report entitled *Review of the Governance Structures within Carlow/Kilkenny/ South Tipperary Mental Health Services* (HSE, 30 May 2014) The findings in that report are similar to the findings in this report.

The Commission, cognisant of the many reviews of aspects of health services nationally and internationally where recommendations have not been implemented, chose, what we refer to as a Targeted Intervention approach to ensure that the recommendations that would emanate from this review would not suffer a similar fate. A targeted intervention approach includes a review, implementation plan to address recommendations and a follow-up inspection to independently verify actions taken by the service concerned. This is the first time that the Commission adopted this approach and there is learning for the Commission as well as for the services concerned. The timeframe for completion of the overall process, took longer than initially anticipated. Throughout the entire process, the Commission was steadfast in its belief that a review with recommendations, in the absence of an implementation plan and subsequent independent verification by the Office of the Inspector of Mental Health Services of the implementation, would not lead to the required changes.

The Commission received updates on the progress of the review on 15 August 2014; 4 December 2014; 18 February 2015; 20 March 2015; 24 April 2015; 13 May 2015 and 25 June 2015. This report provides the findings of the Review Team, their 19 recommendations, the subsequent Implementation Plan provided by the HSE to address the recommendations, and a follow-up inspection to independently verify the actions taken by the HSE. The independent verification by the Office of the Inspector of Mental Health Services from 5th to 8th May, 2015 of the actions undertaken by the HSE confirm that 11 of the recommendations were fully completed, 7 partially completed and one was not completed. In relation to the one recommendation that was not completed the National Director for Mental Health Services subsequently confirmed that the practice of transferring residents to community residential facilities for the purpose of vacating beds had now ceased. This will be independently verified by the Inspector on subsequent inspections.

The principal consideration of the Commission is to ensure that the mental health services in Ireland truly place the service user first, day in and day out, so that they are provided with a safe, compassionate, recovery oriented service.

The findings in this report indicate that in the services reviewed this was not always the case. This review identified warning signs that could and should have alerted the system to problems developing in the region.

The Commission acknowledges that there were a number of reasons identified including staffing challenges in terms of vacancies and locum positions across the service. The disengagement

of senior clinical staff, for whatever reason, from governance of mental health services must never be tolerated and must be acted upon speedily by the HSE to ensure that service users and their families receive safe, compassionate, recovery-oriented care. All mental health care professionals must be accountable for what they do to ensure service users, families and the general public are protected. Safety and quality mental health services flourish where a culture of openness, trust, respect and caring is evident among healthcare professionals, managers and service users. It is noted that this matter has been addressed by the HSE on foot of the recommendations in the aforementioned governance review report and also this report; however, it was allowed to continue for far too long. The HSE must ensure that it remains vigilant and take immediate steps to rectify any regression in clinical governance in Carlow/Kilkenny and South Tipperary mental health services.

The Commission is mindful of the significant steps that have been taken to re-orientate the Carlow/Kilkenny/South Tipperary mental health services in line with the national mental health policy entitled *Vision for Change* (Department of Health, 2006). Therefore, the Commission is not requesting a root and branch re-organisation as the national mental health system has already had many of those. The Commission takes the view that a fundamental cultural change is required which can largely be implemented within the system that has been created by the new reforms within the region. This cultural change must foster a shared understanding of putting the patient first. It can be easy to do the right things on a good day, however, health professionals and managers must do the right things every day, including on the difficult days.

The system of review of sudden unexplained deaths within the mental health service under review was not timely. HSE internal systems analysis and commissioned external reviews can take many months if not years to be completed as is evidenced in this report. This delay denies service users, their families and the staff working in mental health services at the frontline or in management positions, of pivotal information in some instances, that if available expediently, may assist in mitigating risks for other service users. It will not bring back a loved one but it may provide some consolation for families knowing that it may prevent the risk of serious harm to others. Again, it is noted that since the commencement of this review, the HSE has introduced a new process for systems analysis and incident management and this is welcomed. The Commission believes that the HSE must continue to keep this process under review to ensure that it functions as intended and provides timely information to consolidate learning and make core recommendations for service user safety. The Commission will continue to monitor progress through the inspection process.

Openness, candour, compassion and transparency are gaining renewed traction within all areas of health care provision and they apply equally to mental health services. The Commission, as the regulator of mental health services, will continue to place a relentless focus on these areas. We will also continue to promote and encourage high standards and good practices in mental health services in accordance with our statutory remit.

John Saunders
Chairman

PART 2: EXECUTIVE SUMMARY

In March 2014, the Office of Inspector of Mental Health Services was requested by the Mental Health Commission to carry out a Targeted Intervention into service user safety and governance in the Carlow/Kilkenny/South Tipperary Mental Health Services. The Targeted Intervention Team was requested to report within two weeks of the commencement of the process.

The Terms of Reference of this Targeted Intervention required the Inspectorate to carry out a review of Mental Health Services in the catchment area of Carlow/Kilkenny/South Tipperary with particular emphasis on (i) service user safety culture; (ii) clinical and corporate governance; (iii) sudden unexpected deaths and serious untoward incidents; (iv) communication between the service and service users, families and carers.

The Targeted Intervention Team began its work on 31 March 2014 when it visited Kilkenny and conducted a review of documentation together with a series of interviews of senior clinicians, managers and service user representatives. The Team identified a number of concerns under these four headings, including:

- The conduct of examinations, assessments, including assessments of risk and suicidality, and reviews in terms of frequency, scope and appropriateness;
- The identification and remedying of ligature points;
- Bed management;
- The service being provided to 16 and 17 year old adolescents in South Tipperary;
- The complexity of clinical and corporate governance structures and processes and the engagement of consultants with these structures and processes;
- Staffing levels and composition of teams;
- The management of incidents;
- Communication with service users and their families.

The Targeted Intervention Team's findings are set out in full in Chapters 9, 10 and 11 of this report. On foot of these findings, the Targeted Intervention Team has made 19 recommendations.

On 19 February 2015 the Chief Executive wrote to the HSE Area Manager requesting a composite report on the service user deaths which occurred in Carlow/Kilkenny/South Tipperary between January 2012 and March 2014. This was received by the Mental Health Commission on 17 April 2015.

In accordance with the relevant policy[1], the Acting Inspector of Mental Health Services wrote to the HSE Area Manager on 13 March 2015, requesting a draft Implementation Plan to address the issues identified in this report. This plan was received on 2 April 2015 and was accepted by the Commission on 24 April 2015.

Paragraph 8.12.4 of the Policy states at Stage 2 that "the Commission will consider the draft Implementation Plan proposed by the senior management of the mental health service and reserves the right to request that changes be made to the plan. The Commission will either approve or decline the Implementation Plan proposed by the senior management team of the mental health service."

Following receipt of the implementation plan, an inspection team carried out an inspection of the service from 5 to 8 May 2015, to determine whether the recommendations had been implemented. The report of this inspection was forwarded to the service for factual corrections and the report was finalised on 28 May 2015.

The Targeted Intervention Team would like to convey its sympathy to and acknowledge the distress and grief experienced by the families of those bereaved and those affected by the incidents referred to in this report.

1. Mental Health Commission Policy on Handling Complaints or Concerns about Quality, Safety or Welfare in Mental Health Services – Chapter 8, Targeted Interventions

PART 3: BACKGROUND

Between January 2012 and March 2014, 13 service users died by apparent suicide while under the care of the Carlow/Kilkenny/South Tipperary Mental Health Services. Three of these deaths occurred in the Department of Psychiatry, St. Luke's Hospital, Kilkenny; two within 24 hours of discharge from the Department of Psychiatry; four occurred while the service users were under the care of the Home Based Treatment Team; one died while in a crisis house; and three died while under the care of the community mental health services.

LOCATION	NUMBER OF APPARENT SUICIDES
Department of Psychiatry	3
Within 24 hours of discharge from the Department of Psychiatry	2
Kilkenny Home Based Treatment Team	2
Carlow Home Based Treatment Team	2
Greenbanks Crisis House	1
Acute Day Service	2
Outpatient	1

Four serious untoward incidents involving service users also took place within the Carlow/Kilkenny/South Tipperary Mental Health Services.

- One resulted in the death of a relative of a service user.
- One service user suffered serious burns while in the Department of Psychiatry.
- One service user had two serious episodes of self-harm within a short timeframe, while resident in a crisis house.
- A serious physical assault was carried out by a service user on a member of the public.

The Mental Health Commission and the Inspector of Mental Health Services were made aware of difficulties in the clinical governance process and alleged cluster of unexpected deaths through correspondence from a group of consultant psychiatrists working within the service in January 2013. Further correspondence ensued between the Inspector of Mental Health Services, the Executive Clinical Director and this consultant group over the subsequent months.

On 3 September 2013, the Inspector of Mental Health Services convened a catchment area meeting with senior clinical and management staff in Carlow/Kilkenny Mental Health Services.

On 25 November 2013, the Chief Executive requested a meeting with the HSE National Director of Mental Health and on 29 November 2013, the Chief Executive and the Director of Standards and Quality Assurance in the Mental Health Commission met with the HSE National Director of Mental Health, Executive Clinical Director and the Area Manager of Carlow/Kilkenny/South Tipperary regarding clinical governance and sudden unexpected deaths. The Health Service Executive confirmed that arrangements were in place for a review of the governance process and this commenced in December 2013. The report entitled the HSE Review of the Governance Structures within Carlow/Kilkenny/South Tipperary Mental Health Services report was published on 30 May 2014. At the meeting on the 29 November 2013, the HSE also confirmed that all sudden unexpected deaths were being reviewed.

On 7 March 2014, following an unannounced inspection of the approved centre at the Department of Psychiatry, St. Luke's Hospital, Kilkenny, an assistant inspector of Mental Health Services informed the Chief Executive of the Mental Health Commission of a serious concern regarding the non-compliance with the condition attached to the registration of the approved centre. The condition required full compliance with Article 15 of the Regulations, Individual Care Plan.

On 10 March 2014, an assistant inspector wrote to the Executive Clinical Director requesting information on the deaths of two service users whose deaths has been identified by the inspection team during the inspection of the approved centre on 5 and 6 March 2014.

On 13 March 2014, the Area Manager of the Carlow/Kilkenny/South Tipperary Mental Health Services informed the Chief Executive of the Mental Health Commission that four sudden unexplained deaths had occurred in the Carlow/Kilkenny/South Tipperary Mental Health Services between 31 January 2014 and 3 March 2014.

The Mental Health Commission, at its meeting on 21 March 2014, requested the Acting Inspector of Mental Health Services to carry out a Targeted Intervention to review service user safety, governance issues and serious untoward incidents in the Carlow/Kilkenny/South Tipperary Mental Health Services.

PART 4: ESTABLISHMENT OF THE TARGETED INTERVENTION

A Targeted Intervention is an outcomes focused, quality improvement process.

This Targeted Intervention was established under the Mental Health Commission Policy on Handling Complaints or Concerns about Quality, Safety or Welfare in Mental Health Services, 2009 following a request by the Mental Health Commission.

The Criteria for Targeted Intervention may be commenced where an assessment of the *prima facie* evidence indicates that there may have been or there may be:

1. Quality, safety or welfare issues in the carrying on of an Approved Centre or other premises where mental health services were provided that have posed, were posing or were likely to pose a serious risk to service users; or

2. Quality, safety or welfare issues in the care and treatment provided to a specified service user that have posed, were posing or were likely to pose a serious risk to the specified service user; or

3. Compliance concerns with the provisions of the 2001 Act, the Approved Centre Regulations 2006 or the various Rules and Codes of Practice that have been issued by the Commission that have posed, were posing or were likely to pose a serious risk to service users in a specified mental health service.

The Commission recognises that the establishment of an inquiry may not always be the most appropriate way to achieve improvements in a service or services and, therefore, will consider whether a targeted intervention might offer a more effective response to the concerns raised, particularly where:

1. The service is co-operating fully and openly with the Commission;

2. Management have accepted the need for urgent improvement and have expressed their intention to agree to an Implementation Plan to tackle the quality, safety or welfare issues;

3. A targeted intervention is more likely to achieve timely improvements in the services provided to residents or other service users;

4. There is capacity within this service to deliver these improvements;

5. The Commission has already identified some of the reasons for the risk to the health and/or welfare of service users or believes that the reasons can be quickly identified.

PART 5: TERMS OF REFERENCE

1. To carry out a review of service user safety in mental health services in Carlow/Kilkenny/South Tipperary as per the criteria for Targeted Intervention with particular emphasis on the following:
   - 1.1 Service User Safety Culture.
   - 1.2 Clinical and Corporate Governance at local, regional and national level.
   - 1.3 Serious Untoward Incidents including:-
     - (a) Identification, assessment, mitigation and dissemination of learning.
     - (b) Communication between the mental health services and service users, carers and families.

2. If, during the course of the Review, the Office of Inspector of Mental Health Services forms the opinion that there were further serious risks to service user safety, it must inform the Chief Executive of the Mental Health Commission immediately.

3. Prepare and submit findings as per Section 8.12.4 (i) of Policy regarding Targeted Interventions (p.20) by Monday 7 April 2014.

4. Timeline for completion of Draft Final Report as per Section 8.13 and 8.14 to be determined following receipt of (3) above.

PART 6: MEMBERSHIP OF THE TARGETED INTERVENTION TEAM

The team consisted of:

- Dr. Fionnuala O'Loughlin, MCN 08108, Assistant Inspector of Mental Health Services (Acting Inspector of Mental Health Services from 18 March to 28 March 2014)
- Dr. Susan Finnerty, MCN 009711, Assistant Inspector of Mental Health Services
- Mr. Sean Logue, Assistant Inspector of Mental Health Services
- Ms. Orla O'Neill, Assistant Inspector of Mental Health Services
- Ms. Colette Ryan, Senior Administrator, Mental Health Commission

PART 7: METHODOLOGY

This section summarises the methodology used by the Targeted Intervention Team in conducting this Targeted Intervention.

In January 2013, the Inspector of Mental Health Services received correspondence from nine consultants working in Carlow/Kilkenny/South Tipperary which referred to "*a disproportionate number of violent deaths in the Carlow Kilkenny/ South Tipperary Mental Health Services over the past 12 – 18 months*". It was against this background that the team limited its review to the period from January 2012 to March 2014.

7.1 Document Review

The Targeted Intervention Team reviewed an extensive amount of documentation including correspondence, policies, procedures and guidelines, minutes from management and clinical governance group meetings, reports of the Inspector of Mental Health Services, incident reports and service user clinical files. A full list of this documentation (with the exception of service user clinical files and incident reports) can be found at Appendix 2.

7.2 Interviews

The Targeted Intervention Team conducted a series of interviews on 31 March 2014, 1 and 2 April 2014. Interviews focused on the following topics: patient safety; bed management; home based treatment; crisis houses; governance; the review of incidents by the service; and communication.

The Targeted Intervention Team interviewed 33 people in total including the HSE Area Manager, the Executive Clinical Director, the Clinical Director for South Tipperary, the Area Director of Nursing, the Manager of the Service, nine of the 11 other consultant psychiatrists working in the service, other senior clinicians and service user representatives.

7.3 Visits to Mental Health Sites

The Targeted Intervention Team visited the following sites:

- The Department of Psychiatry, St. Luke's Hospital, Kilkenny
- The Home Based Treatment Team, Kilkenny
- Greenbanks Crisis House, Carlow
- Glenville Crisis House, Clonmel

7.4 Factual Corrections and Responses

In May 2014, following completion of the draft report of initial findings, the report was sent to all participants in the process. The participants were invited to submit factual corrections and observations on the report to the Targeted Intervention Team. The Targeted Intervention Team carefully considered all factual corrections and submissions received at that time.

The Mental Health Commission reviewed this draft at its meeting on 15 August 2014. The Commission subsequently requested the team to review further incident reports, which had not been made available to the Targeted Intervention Team in March 2014. This visit was completed in October 2014.

In January 2015, a further opportunity was provided to those who had not responded to the earlier invitation to provide factual corrections and general observations to submit their views.

This concluded the information gathering and analysis phase of the Targeted Intervention process as per the relevant Mental Health Commission Policy.

PART 8: DESCRIPTION OF CARLOW/ KILKENNY/SOUTH TIPPERARY MENTAL HEALTH SERVICE

During the period under review, the Carlow/ Kilkenny/South Tipperary catchment area had a population of just over 238,463 and a mental health budget of €49 million.

At the time of the Targeted Intervention there were eight sector teams: Kilkenny East, Kilkenny West, Kilkenny North, Carlow North, Carlow South, Clonmel East, Clonmel West and Tipperary/Cashel. There was a Psychiatry of Old Age team in South Tipperary and another in Carlow/Kilkenny. There was also a Rehabilitation team in South Tipperary and another in Carlow/ Kilkenny. There were two Child and Adolescent Mental Health Service (CAMHS) teams in Carlow/Kilkenny and one CAMHS team in South Tipperary. In Carlow/Kilkenny, the CAMHS teams provided care and treatment to children up to the age of 18 years. However, in South Tipperary the CAMHS team only accepted new referrals for children up to and including the age of 15 years.

There was a single point of access for service users to the general adult acute services. All access to acute services in the Carlow/ Kilkenny/South Tipperary was through team co-ordinators, who triaged referrals, arranged for assessments and co-ordinated care.

8.1 Approved Centres

There are three approved centres in the Carlow/ Kilkenny/South Tipperary catchment area.

The acute in-patient unit for Carlow/Kilkenny/ South Tipperary is in the Department of Psychiatry, St. Luke's Hospital, Kilkenny. The Department of Psychiatry is an approved centre with 44 beds and is divided into an acute area and a sub-acute area. Both areas are locked and accessed through a swipe card mechanism. All sector and specialist teams admit patients to the unit. However, at the time of the Targeted Intervention, all in-patients from the South Tipperary area were admitted under the care of a single general adult consultant psychiatrist.

At the inspection of the Department of Psychiatry in March 2014, there were 11 registered psychiatric nurses on duty, including two special *one to one* nurses and two clinical nurse managers by day. There was also an Assistant Director of Nursing on duty. At night, there were eight nurses on duty, which included one clinical nurse manager and two nurses providing special *one to one* care. The number of nurses has been increased by one on each shift since the 21 March 2014.

The second approved centre is Heywood Lodge in Clonmel, South Tipperary. This has two wards (East and West) and has 40 beds. It provides continuing care and rehabilitation services to mostly elderly residents.

The third approved centre is located in St. Gabriel's Ward, St. Canice's Hospital, Kilkenny.

Neither Heywood Lodge nor St. Gabriel's Ward form part of this Targeted Intervention.

8.2 Acute Community Services

At the time of the Targeted Intervention, there were three Home Based Treatment Teams (HBTT) in the catchment area: one in Carlow, one in Kilkenny and one in South Tipperary. These teams operated on a seven-day basis and consisted of nurses only. The consultant of each community mental health team had overall responsibility for service users of their sector, who were being treated by the HBTT nurses. Members of the HBTT routinely attended the community mental health team meetings.

In each sector there was a multidisciplinary community mental health team, none of which was sufficiently staffed according to the recommendations of *A Vision for Change*. Day Hospital and Acute Day Services were provided in Carlow, Kilkenny and South Tipperary.

8.2.1 Crisis Houses

A Vision for Change states that crisis houses are used for crisis intervention and for acute respite purposes. A crisis period should be brief, usually between 24 and 72 hours. It goes on to state that a crisis house is not an intensive treatment option but rather a place of refuge, of understanding and of support for individuals

in crisis. It may offer an alternative to in-patient care for a proportion of those who would otherwise be admitted into hospital.

There were two crisis houses in the catchment area: Glenville House, an eight-bed residence in Clonmel; and Greenbanks House, a 12-bed residence in Carlow. Both were staffed by two nurses, 24 hours a day. Both had an open door policy and residents were free to come and go as they pleased. Referrals came from the Department of Psychiatry and community services. The policies of the Carlow/Kilkenny and South Tipperary Mental Health Services differed in their criteria for admission to the crisis houses.

On at least two occasions, service users were transferred from the Department of Psychiatry to the crisis houses for the purpose of vacating beds for other service users being admitted to the Department of Psychiatry.

8.2.2 Home Based Treatment Teams (HBTTs)

Carlow/Kilkenny/South Tipperary had three HBTTs: HBTT Kilkenny, HBTT Carlow and HBTT South Tipperary. The Targeted Intervention Team met with four members of the HBTT Kilkenny and also with the acting co-ordinator from South Tipperary HBTT and the acting co-ordinator from Kilkenny HBTT. The acting co-ordinator from the Carlow HBTT did not attend for interview.

The HBTTs consisted of one team coordinator at Acting Clinical Nurse Manager (CNM) 3 grade, one CNM2 and registered psychiatric nurses (RPN). Staff on the Kilkenny HBTT could be reassigned to the Department of Psychiatry during staff shortages.

Most of the referrals were from the community mental health teams and clinical responsibility remained with the consultant psychiatrist member of these teams. Following referral, the HBTT carried out an assessment and completed an Initial Screening Assessment Form. A service user safety plan was also completed, in collaboration with the service user. The average period of time a service user remained under the care of the HBTT was between one and two weeks. Although it was a seven day service, no assessments took place after 1700h. At the time of the Targeted Intervention, Kilkenny HBTT had a caseload of six service users, while South Tipperary had a caseload of five service users.

Staff had received training in Prevention and Management of Aggression and Violence (PMAV), team building, Cognitive Behaviour Therapy (CBT), Brief Solution Focused Therapy, STORM (Skills-based Training on Risk Management) and ASIST (Applied Suicide Interventions Skills Training). A number of nursing staff had completed a Nurse Prescribing Course.

In the Carlow, Kilkenny and South Tipperary HBTTs, joint assessments were always undertaken by both a member of the HBTT and a non consultant hospital doctor (NCHD). This assessment usually took place in the Department of Psychiatry, St. Luke's Hospital or in the acute Day Services in Kilkenny because of the unavailability of NCHDs to attend the homes of service users.

Each multidisciplinary team (MDT) held weekly meetings and members of the HBTT attended these meetings to discuss their caseload.

PART 9: FINDINGS IN RELATION TO SERVICE USER SAFETY CULTURE

9.1 Department of Psychiatry

Between January 2012 and March 2014, the following serious incidents[2] occurred within the Department of Psychiatry:

- Three residents died by apparent suicide.
- One resident discharged themselves against medical advice and died by apparent suicide within a few hours of leaving the hospital.
- Self-harm resulted in serious burns to one service user.
- Three residents sustained fractures following falls.

In addition, seven days of clinical notes were absent from the clinical file of one service user who absconded from the approved centre. These notes were not located by staff during the period of the Targeted Intervention.

9.1.1 Ligature Anchor Points

The ligature anchor points identified as contributing to the deaths of two residents in the previous 12 months were remedied following the inspection of the approved centre in 2013.[3] The Carlow/Kilkenny/South Tipperary service subsequently completed a ligature anchor point audit in October 2013.[4] However, a further apparent suicide occurred in March 2014 using a ligature anchor point [5] which had been identified in the audit. This ligature anchor point was subsequently remedied and actions taken to remedy similar ligature anchor points within the unit.[6]

9.1.2 Self Injury

Cigarette lighters were prohibited in the acute area of the Department of Psychiatry. However, one service user obtained access to a cigarette lighter and used it for the purpose of self-harm.[7] This occurred notwithstanding the availability of a safe cigarette lighter attached to the wall in the courtyard of the unit.

9.1.3 Risk Assessment

The suicide risk assessment carried out at the initial screening interview of residents being admitted to the Department of Psychiatry, did not always result in a risk management plan. In one case, where a service user had attempted suicide and then went on to complete apparent suicide, there was no mention of an assessment of high risk in the interim care plan and there was no risk management plan.

Furthermore, the risk assessment completed on admission of this patient stated there were no previous attempts at self-harm. This risk assessment was at variance with the admission assessment and mental state examination which found that the service user had a previous history of self-harm. No follow-up risk assessment was completed prior to this resident's transfer from the acute area to the sub-acute area of the unit.

In other cases, a full Sainsbury Clinical Risk Assessment was not completed. [8] In the case of another resident who died by apparent suicide, although the risk assessment in the clinical file indicated a high risk of suicide, the service user had been admitted to the sub-acute area[9] which does not have the same level of nursing observation as the acute area.

It is not possible to state with any certainty what alternative outcomes, if any, might have ensued had adequate risk assessment and management measures been taken.

9.1.4 Admission Process to the Department of Psychiatry

In the case of one resident who subsequently died by apparent suicide, there was no record of a medical assessment on admission to the Department of Psychiatry. Consequently, there was no record of a mental state examination,

2. Following a review of clinical files and the incident log
3. Report of the Inspector of Mental Health Services dated March 2013
4. Service Ligature Point Audit dated 9 October 2013
5. Service User Clinical File
6. Confirmed by the T.I. Team by way of visual inspection
7. Service User Clinical File and Incident Report
8. Service User Clinical Files
9. Service User Clinical File

physical examination or risk assessment despite the resident having engaged in an episode of self-harm immediately prior to admission. In addition, there was no record of an initial care plan. [10]

Service users presenting to the Carlow/Kilkenny service had a comprehensive assessment known as an Initial Screening Interview. In circumstances where an Initial Screening Interview had been carried out within the previous six months, a Short Screening Interview was completed at subsequent presentation. The Short Screening Interview does not provide sufficient information to carry out a comprehensive admission assessment. This was in contrast to South Tipperary Mental Health Service where the Initial Screening interview was used for all presentations.

9.1.5 Discharge from the Department of Psychiatry

Three service users died by apparent suicide within 24 hours of discharge from the Department of Psychiatry. [11]

- The clinical file of one service user did not record an assessment by a doctor in the 72 hours prior to discharge.
- Another service user was discharged after a brief period of admission. The reason for discharge after such a brief period as an in-patient admission was not documented.
- Another service user had discharged themselves against medical advice.

9.1.6 Fractures

Three residents sustained five fractures[12] following falls in the Department of Psychiatry. There did not appear to be any common factors between these falls, following consideration of age profile, location and medication. It was of note, however, that one of these residents did not have an X-ray for two days, despite a complaint of pain and observation of a limp following a fall.[13] A second resident did not have an X-ray for four days following a reported fall, despite on-going complaints of pain.[14] In the case of another fracture, it was not detected until an X-ray was carried out some ten days after the resident sustained a fall.[15] The Targeted Intervention Team could not find any apparent reason why the X-rays should have been delayed in these cases.

9.1.7 Bed Management

Following the closure of St. Michael's Unit in South Tipperary, the bed occupancy in the Department of Psychiatry increased significantly as a result of the admission of service users from South Tipperary. Some consultant psychiatrists and assistant directors of nursing expressed the view that there were bed shortages and a pressure to discharge early.[16] The Team was informed by staff in Greenbanks that, on occasion, residents were accommodated in the crisis house in order to vacate a bed in the Department of Psychiatry which was required for a new patient to be admitted.

The clinical file of one service user who had been resident in the Department of Psychiatry indicated a transfer to a community residence at 0300h to make room for the admission of another resident. This service user had been described by the treating team, two days previously, as being unwell and vulnerable.[17] There was no record of a risk assessment taking place prior to transfer. This transfer did not take place for any treatment purposes or at the request of the service user and was not in their best interests.

9.1.8 Elderly Service Users in the Department of Psychiatry

When residents who were already under the care of the specialist Old Age Psychiatry Team in South Tipperary were admitted to the Department of Psychiatry, it was under a General Adult psychiatrist rather than the Old Age Psychiatry team. Consequently, specialist care was not available to them.

In the minutes of the South Tipperary Adult Mental Health Services Clinical Governance Quality Assurance Forum in October 2012, it was agreed that the Carlow/Kilkenny Old Age psychiatrist would provide a service to Old Age Psychiatry service users in the Department of Psychiatry. It should be noted that the relevant consultant psychiatrist was not in

10. Service User Clinical File
11. Service User Clinical Files
12. Service User Clinical Files and Incident Reports
13. Service User Clinical File
14. Service User Clinical File
15. Service User Clinical File
16. Interviews with senior clinical staff
17 Report of the Inspector of Mental Health Services 2014 – March 2014

attendance at that meeting. However, in the November 2012 minutes of this forum, it was stated that the Old Age psychiatrist was "not prepared" to look after the South Tipperary Old Age Psychiatry residents in the Department of Psychiatry unless the team received an additional nurse.[18] By way of response to the draft report, the relevant consultant stated in writing, in their factual corrections that *"there never have been negotiations locally to enable me…….to take on this work, it would not be safe for me to do so given my current caseload and team resource"*. [19]

9.2 Home Based Treatment

Between January 2012 and March 2014, there were four sudden unexpected deaths of service users being treated by the HBTTs. Another service user had been referred to a HBTT but had not been assessed prior to their death. In three of these cases, even where there had been a history of suicidal behaviour or where the service user was assessed to be depressed, there was no record to indicate that an assessment of suicidality had been carried out. [20]

The service's guidelines states that "The Home Based Treatment Team consists of members of the mental health teams who were specifically assigned to HBT".[21] The Targeted Intervention Team found that the HBTT consisted solely of nursing staff. There were no dedicated NCHDs and the HBTTs were dependent on the NCHDs from Community Mental Health Teams or the NCHD on call to provide psychiatric assessment and treatment.[22]

Clinical responsibility for service users treated by the HBTT remained with the Community Mental Health Team (CMHT) and members of the HBTT routinely attended the CMHT meetings.[23] At times of nurse staff shortages in the Department of Psychiatry, members of the Kilkenny HBTT were redeployed to the unit.[24] This, in turn, caused staff shortages on the HBTT. A consultant psychiatrist reported that, on one occasion, this resulted in their inability to discharge a resident to the HBTT. Information about such staff shortages on the HBTT was not always communicated to relevant treating teams.[25]

9.2.1 Psychiatric Reviews

In the case of two service users who died by apparent suicide, the Targeted Intervention Team found no evidence of a psychiatric assessment having been carried out by a doctor (NCHD or Consultant) for seven days. [26]

9.2.2 Therapies

Nursing staff on the HBTTs have trained in a number of different therapies in order to provide therapeutic interventions for service users. These included Cognitive Behavioural Therapy (CBT), relaxation, Wellness Recovery Action Plan (WRAP), Applied Suicide Intervention Skills Training (ASIST) and Skill Based Training on Risk Management (STORM). However, there was little evidence in the clinical files examined of the HBTTs providing therapies other than support and reassurance.

9.3 Crisis Houses

One service user had two serious episodes of self-harm within a short time frame while resident in a Crisis House. [27]

9.4 Community Mental Health Service

One service user who was being treated in the community was involved in an incident which resulted in the death of a family member. Another service user who was being treated in the community carried out a serious physical assault on a member of the public. [28] Both of these cases have been the subject of criminal prosecutions.

9.5 Child and Adolescent Mental Health Services

There were three Child and Adolescent Mental Health Services (CAMHS) teams in Carlow/Kilkenny/South Tipperary. According to national policy, all children up to the age of 18 years must be assessed and treated by a CAMHS team.[29]

18. South Tipperary Adult Mental Health Services Clinical Governance Quality Assurance Forum Minutes 2 November 2012
19. Factual Corrections Form dated 9 June 2014
20. Service User Clinical Files
21. Home Based Treatment Team Guidelines – Section 3.1
22. Interviews with senior clinician and HBTT Co-ordinators
23. Home Based Treatment Team Guidelines – Section 10.3 and Factual Corrections
24. Interviews with HBT Team Members and Factual Corrections
25. Interview with senior clinician
26. Service User Clinical Files
27. Service User Clinical File
28. Service User Clinical Files
29. A Vision for Change – Recommendation 10.2

In South Tipperary, the consultant psychiatrist did not accept new referrals of adolescents aged 16 and 17 years.[30] The reason for this, as stated by the consultant psychiatrist in their factual corrections, was "because the HSE has not adequately resourced same"[31]. The ECD acknowledged that there was a need for a second consultant psychiatrist in CAMHS for the South Tipperary area but indicated that it was proving difficult to recruit a suitable candidate.[32] For children aged 16 and 17 years who presented for the first time to the South Tipperary service, assessment took place in the Emergency Department of the South Tipperary General Hospital by the general adult psychiatric NCHD on call, after 1700h.[33] This situation resulted in these children not receiving an adequate safe service. Concern about the risks associated with the lack of service for newly presenting 16 and 17 year olds was articulated by most of the interviewees of the Targeted Intervention Team and in the minutes of the Executive Management Team.

In South Tipperary, when the consultant psychiatrist was on leave, no newly referred children were seen by the local CAMHS team.[34] This had resulted in long waiting lists of 2-3 years and delays in assessment and treatment.[35] There was a facility whereby children in need of urgent assessment could be referred to a private clinician located outside the county.

By way of contrast with the above, the Targeted Intervention Team was advised that two CAMHS teams in Carlow/Kilkenny provided a service for children and adolescents up to 18 years of age.[36]

Recommendations:

1. Assessment of suicidality should be carried out at each clinical evaluation of mental state. This should be evaluated by audit on a regular basis.

2. Service users should have a risk assessment which leads to a clearly articulated and implemented risk management plan. Risk assessments should be updated at the transitional stages of the care pathway. This should be evaluated by audit on a regular basis.

3. Training in assessment and management of risk should take place to build a culture of patient safety.

4. Heads of discipline should ensure the supervision of clinical staff who carry out risk assessments to support a good standard of practice.

5. A full and comprehensive admission assessment by NCHDs should be carried out and documented in the clinical files, for all service users who are admitted to the service. This should be evaluated by audit on a regular basis.

6. The Home Based Treatment Team should be consultant led and multidisciplinary and should include a dedicated NCHD.

7. HBTT staff should not be redeployed from the teams in order to staff the Department of Psychiatry.

8. Where an external review of serious untoward incidents and sudden unexpected deaths is indicated, this should be completed in a timely manner.

9. All sudden unexpected deaths and serious untoward incidents should be followed by a review by the multidisciplinary team with responsibility for the care of the service user. This does not preclude a systems review by the HSE where indicated.

10. Consultant psychiatrists should be included in the internal review process of sudden unexpected deaths and serious untoward incidents, as appropriate.

30. Executive Management Team Minutes 9 January 2014 and 23 January 2014 and interview with relevant consultant
31. Letter dated 4 June 2014
32. Interview with ECD
33. Interview with senior clinician and letter dated 5 June 2014
34. Interview with relevant consultant
35. Interview with relevant consultant
36. Interviews with senior clinicians

PART 10: FINDINGS IN RELATION TO CLINICAL AND CORPORATE GOVERNANCE

10.1 Reconfiguration of Services

In June 2012 the approved centre at St. Michael's Unit, Clonmel was closed as part of the re-configuration of the Carlow/Kilkenny/South Tipperary catchment area. Following the closure of St. Michael's Unit, service users from North Tipperary who required admission to an approved centre were admitted to the Acute Psychiatric Unit in the Mid-Western Hospital, Ennis. Service users from South Tipperary were admitted to the Department of Psychiatry, St. Luke's Hospital, Kilkenny, if admission was required.

The reconfiguration of the services included the setting up of Home Based Treatment Teams, a Crisis House in Clonmel and the refurbishment of Day Hospitals in Cashel and Clonmel. Heywood Lodge, Clonmel, an approved centre which provides Continuing Care and Rehabilitation, was also opened in 2012 and facilitated the closure of St. Luke's Psychiatric Hospital in Clonmel.

Prior to, and around the time of the closure of St. Michael's Unit, there was significant disquiet amongst the public and some members of the mental health services about the loss of the unit. It is common knowledge that the amalgamation of the two services has proved difficult.

There was on-going conflict between the majority of the consultant psychiatrist group and the Executive Clinical Director regarding governance. There was an expression of 'no confidence' by the majority of the consultant group in the Executive Clinical Director in November 2012 and there was a significant disengagement by consultants from local governance meetings. [37] Prior to the Targeted Intervention, two previous rounds of facilitation had failed to resolve these differences.[38] In the summer of 2014, the HSE published a review of the governance structures within Carlow/Kilkenny/South Tipperary. [39]

10.2 Description of Governance Structures

The overall governance structure is depicted at Appendix 1. The catchment area had an Executive Management Team (EMT) which met fortnightly. The membership of the Executive Management Team comprised the Executive Clinical Director (who was also the clinical director of Carlow/Kilkenny), the Clinical Director of South Tipperary, the Manager of Carlow/Kilkenny/South Tipperary Mental Health Services, the Service Manager, the Area Director of Nursing, the Heads of Discipline of Occupational Therapy, Social Work and Psychology and a service user representative. [40]

At a more local level, the service operated a system of governance groups which comprised members of staff from medical, nursing, health and social care professionals, administrative and service user representation. There were four of these groups:

- Carlow Clinical Governance Group
- Kilkenny Clinical Governance Group
- South Tipperary Clinical Governance Group
- In-patient (DOP) Clinical Governance Group.

These groups were perceived by some clinical staff to be excessively large and unwieldy with up to 21 members in each group.[41] Many of the consultant psychiatrists assigned to attend these meetings did not attend as they had stated their lack of confidence in the governance process.[42] The service user representatives interviewed clearly articulated their concerns about the failure of some consultant psychiatrists to participate in the local governance meetings. One consultant psychiatrist expressed reservations about discussing incidents of apparent suicide in a

37. Interview with Area Manager
38. Facilitation Process Report by John Hillery dated 28 October 2010 and interview with area manager
39. Review of the Governance structures within Carlow/Kilkenny/South Tipperary MHS 30 May 2014 – Dr. Colm Henry and Dr. Eamonn Moloney
40. Clinical Governance Structure for Carlow, Kilkenny and South Tipperary Mental Health Services
41. Interviews with senior clinicians
42. Interviews with senior clinicians

meeting at which representatives of service users were in attendance.[43]

An Executive Integrated Governance Team, which consisted of the EMT with a representative from each of the Local Governance Groups and the Quality and Patient Safety Manager, met monthly.

In July 2013, the Child and Adolescent Mental Health Service came under the governance of the Carlow/Kilkenny/South Tipperary Mental Health Services.[44] The three CAMHS consultant psychiatrists expressed the view that this was an inappropriate governance structure for CAMHS. One consultant psychiatrist stated that there was no benefit to a CAMHS consultant attending a governance group which included both the psychiatry of old age and general adult mental health services. [45]

10.3 Staffing

There were difficulties in staffing the multidisciplinary teams. At the time of the Targeted Intervention, three of the seven general adult consultant psychiatrist posts (excluding the Executive Clinical Director and Clinical Director of South Tipperary) were filled by Locum Consultants. A further consultant post was vacant. At times, there were instances where there was no clinical lead when a consultant psychiatrist was on leave. On some occasions, the clinical lead was only available by telephone.[46] Again, because of a deficit in providing locum cover, outpatient clinics had been cancelled for two months due to a consultant being on leave. [47]

Only three of the six psychology posts were filled in the community mental health teams in Carlow/Kilkenny/South Tipperary.[48]

As is clear from the above, none of the community mental health teams were sufficiently staffed.

The service was unable to fill all NCHD posts through the normal recruitment process due to an absence of suitable candidates.[49] Agency staff were being used to fill the vacancies. In the minutes of the Executive Management Team meeting in May 2013, the difficulty in filling NCHD posts was highlighted. In addition to the financial implications for the service (agency staff are more costly than those directly employed by the services), this process has an effect on continuity of care and treatment for service users. Similarly, the employment of locum consultant psychiatrists can have the same effect.

10.4 Risk Register

The service maintained a Risk Register which was reviewed by the Executive Management Team. Individual staff members could rate an item of risk and forward an item of concern to their line manager who then brought it forward to the Executive Management Team for discussion. There is a risk register procedure in place since 2013 which outlines the process for inclusion of items on same. At each meeting, items forwarded by staff, in addition to the Executive Management Team's own concerns regarding risk, were discussed and a decision was taken as to whether they should be placed on the Risk Register.

There was a level of unhappiness across disciplines that items of concern to them were not acknowledged as such by the Executive Management Team and, therefore, were not placed on the Risk Register. It was unclear to staff why this was so.[50]

Recommendations:

11. Consultant psychiatrists should engage with all governance processes.
12. The Executive Management Team should disseminate reports of internal and external reviews of SUIs and SUDs through an appropriate clinical governance forum.
13. The service should actively seek to appoint senior clinical personnel to permanent positions.
14. Policies on clinical and operational procedures should be standardised across the whole Carlow/Kilkenny/South Tipperary area.

43. Interview with relevant consultant
44. Kilkenny Catchment Area Report of the Inspector of Mental Health Services 3 September 2013, page 20 and Executive Management Team Meeting Minutes 31 July 2013
45. Interviews with relevant consultants
46. Interviews with Assistant Directors of Nursing
47. Interview with senior clinician and EMT Minutes dated 6 February 2014
48. Interview with head of discipline
49. Interviews with ECD and Area Manager
50. Interviews with senior clinicians and letter dated 2 April 2014

15. All multidisciplinary teams should be fully staffed with medical, nursing and health and social care professionals.

16. A Child and Adolescent Mental Health Service must be provided to 16 and 17 year olds in the South Tipperary area in accordance with national policy.

17. A second CAMHS consultant psychiatrist and team should be appointed to the South Tipperary area.

PART 11: FINDINGS IN RELATION TO SERIOUS UNTOWARD INCIDENTS

11.1 Identification

There was a system in place for the reporting and recording of sudden unexpected deaths and serious untoward incidents. This consisted of the filling out of a "Clinical Incident/ Close Call" Template Form and following the procedures described in the Carlow/Kilkenny/ South Tipperary SUI Pathway.

11.2 Assessment

In terms of the assessment and review of incidents, three of the consultant psychiatrists interviewed reported to the Targeted Intervention Team that they had not been included in any of the Incident Reviews into the Sudden Unexpected Deaths or Serious Untoward Incidents.[51]

There were some differences in the manner in which the reviews of incidents were conducted in Carlow/Kilkenny compared to South Tipperary. In Carlow/Kilkenny, reviews were managed by the Clinical Nurse Manager (CNM3) in consultation with the Clinical Risk Manager.[52] In South Tipperary, it was the multidisciplinary team that reviewed incidents. There were references in the minutes of the South Tipperary Governance Team relating to the need to standardise policies across the whole Carlow/ Kilkenny/ South Tipperary area. [53]

11.3 Mitigation

As referenced at Paragraph 8.1.1, following the occurrence of two fatalities in the approved centre in 2012, the service completed a ligature anchor point audit in 2013.[54] The service remedied the ligature anchor points that were associated with these two sudden unexpected deaths within the Department of Psychiatry. Further ligature anchor points have been remedied since the most recent apparent suicide in March 2014.[55]

In addition, one extra nurse per shift was added to the complement of staff in the Department of Psychiatry. An additional Assistant Director of Nursing was also assigned to the Department of Psychiatry.[56]

11.4 Dissemination of Information to Assist Learning

As referenced above, the Targeted Intervention Team found variances in the manner in which incidents were reviewed based on their geographic location. This, in turn, led to inconsistencies in how information was shared and lessons learned following serious untoward incidents and sudden unexpected deaths. One consultant psychiatrist spoke about relying on text messages from colleagues to learn about deaths and obtain information.[57] There were delays in commissioning and receiving external reports on some sudden unexpected deaths.[58]

It was reported that there was a deficit in providing review reports to clinical leads which led to one consultant psychiatrist resorting to the Freedom of Information Act 2003 to obtain reports into the sudden unexpected deaths in the service. [59]

All incident reports were discussed at the Executive Management Team meetings and forwarded through the Clinical Governance Groups for further discussion.[60] A number of consultant psychiatrists did not attend Local Governance Groups and, therefore, there was limited or no involvement in the review of sudden unexpected deaths and serious untoward incidents within this forum.

11.5 Communication between the mental health services and service users, carers and families

A Vision for Change at 3.1 outlines a model

51. Interviews with consultants concerned
52. Interviews with staff
53. South Tipperary Clinical Governance Minutes dated 14 June 2013
54. Service Ligature Point Audit dated 9 October 2013
55. As observed by the T.I. Team
56. Interviews with senior nursing staff
57. Interview with consultant concerned
58. Interviews with senior clinicians and managers
59. Interview with consultant concerned
60. Factual Correction dated 6 June 2014

for service user involvement in mental health services. The model outlines service user involvement at an individual level in the individual care plan (ICP) process, at community level in advocacy services, at statutory mental health service level with service user representation on catchment management teams and consumer panels, and at national level with a National Service User Executive.

11.6 Consumer Panels

Consumer panels typically comprise service users, carers and independent advocates. Consumer panels were well developed in the catchment area from an organisational perspective. Consumer Panel representatives stated that senior management continued to be fully supportive. Independent advocacy services were provided in the Department of Psychiatry. There was service user representation on the Executive Management Team and consumer panel representation at all local governance team meetings in the Carlow/Kilkenny/South Tipperary Mental Health Services.

The Consumer Panel representatives stated that, on occasion, there had been discord regarding consumer participation at local governance meetings, particularly where sudden unexpected deaths or serious untoward incidents were being discussed.[61] One representative reported that a consultant psychiatrist had expressed a reluctance to discuss apparent suicide in situations where service users were present and this was confirmed by the consultant concerned.

11.7 Communication with Service Users

Overall, the individual clinical files inspected recorded a mixed picture of the level and quality of communication with service users. Approximately half of the records showed good communication and a partnership approach; this was particularly so for those being treated by the HBTT. Communication between in-patients (DOP) and clinical staff was not well recorded in the individual clinical files. This resonated with the views expressed by the Consumer Panel representatives that there was insufficient one to one time with nursing staff within the Department of Psychiatry. The in-patient nursing records were brief in their account of interaction with individual residents. The records were stereotyped in format, with an over-reliance on phrases such as “self-isolating”, “maintaining a low profile”, “no management problem”.[62] The nursing admission record of one service user stated that they were “orientated to the ward and informed of rules and regulations”. Records such as these did not convey a sense of meaningful communication with residents.

11.8 Communication with Family

Several clinical files showed that families were involved in the care process from the outset. Family involvement included:

- Providing collateral information
- Discussing care individually with clinicians and at family meetings
- Contributing to the individual care plan process.

In two instances, there was excellent pre-discharge liaison including family meetings to discuss placement, child care and protection of vulnerable adult issues. The clinical records indicated that these families themselves had been proactive in relation to their involvement in the care process. The HBTTs provided care in individuals’ homes and there was generally evidence of good communication with families.

However, there were exceptions. Some clinical files recorded limited or no contact with, or input from families. One service user who died by apparent suicide the day after discharge, had twice requested a family meeting to discuss discharge but there was no record of this happening.

In the case of one resident who was discharged within 24 hours of admission and who died by apparent suicide, there was no record of consultation with the family prior to discharge.

Consumer panel and service user representatives reported instances of family members being unable to contact the treating responsible consultant psychiatrists despite numerous attempts.

The clinical records showed that, following a death or serious untoward incident, the responsible consultant psychiatrist and key nursing personnel communicated with families

in a timely and appropriate way. Face to face family meetings, support and discussion about the circumstances of a death or incident and information on any investigative processes were provided to families. In some instances, and, in particular, where there had been no previous contact between the family and the treating team, the offer of support was initially declined by the family. In other instances, families met with the treating team and support and communication was provided.[63]

Recommendations:

18. Family members should, with the service user's consent, have appropriate and timely communication with members of the treating team.
19. The transfer of service users from the Department of Psychiatry to other residential facilities to vacate beds for admissions should not take place.

PART 12: CONCLUSIONS

In light of the findings set out above, the Targeted Intervention Team has concluded as follows:

Risks to Service User Safety

Section (2) of the Terms of Reference of the Targeted Intervention states that: *"If, during the course of the Review, the Office of Inspector of Mental Health Services forms the opinion that there were further serious risks to service user safety, it must inform the Chief Executive of the Mental Health Commission immediately"*. The Targeted Intervention Team, while having identified issues of concern during the data gathering and analysis phase of the process, did not consider them to be of such immediate risk as to require immediate notification to the Chief Executive of the Mental Health Commission.

Service User Safety Culture

The Targeted Intervention Team did not identify a common causal factor resulting in the deaths and serious incidents examined. However, a number of factors may have played a role in the sudden unexpected deaths and serious untoward incidents examined. For example, in a number of sudden unexpected deaths across the service, assessment of suicidality may have alerted clinical staff to the risk of suicide. Moreover, there were inconsistencies in the manner in which risk assessments were conducted. As such, the Targeted Intervention Team concluded that either the training for risk assessment was insufficient or it was not being applied. The Targeted Intervention Team also concluded that the level of supervision in conducting risk assessment and formulating a risk management plan was inadequate. The Targeted Intervention Team does not consider the Short Screening Interview to be an adequate assessment tool on admission. Where incidents did occur, the Targeted Intervention Team concluded that that the system for dissemination of information following these incidents did not function well and did not support a safety culture.

In the case of Child and Adolescent Mental Health Services the team concluded that, at the time of the Targeted Intervention, newly presenting 16 and 17 year olds in South Tipperary were not receiving an adequate, safe service.

The Targeted Intervention Team concluded that the practice of transferring residents from the Department of Psychiatry to other community residences and crisis houses merely to vacate beds was not good practice and does not conform to the Mental Health Commission's Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre.

Clinical and Corporate Governance

The Targeted Intervention Team concluded that clinical governance within the service had been undermined because of a lack of cohesion between senior management and the consultant group. The Team agrees with the conclusion of the Henry Report[64] that *"the current situation of non-engagement by consultants cannot continue and represents, in our view, a serious and unacceptable risk to the service."*

The various clinical governance groups did not appear to meet the needs of the various stakeholders and were thus not an effective forum.

The Targeted Intervention Team concluded that there was a heavy reliance on agency and locum staff at all levels which inevitably impacted on continuity of care and treatment.

There was evidence of deep disharmony between the senior management team and some members of the consultant psychiatrist group. At the time of the Targeted Intervention, the team found that this situation remained entrenched and it was extremely unsatisfactory that the situation had been allowed to develop and continue for so long, despite previous attempts at resolution. It led to a fractured service and poor communication between the Executive Management Team and consultant psychiatrists. It is obvious that protracted conflict of this nature in organisations dissipates energy and detracts focus from the delivery of a quality service and has the potential to impact on patient safety.

64. Review of the Governance Structures within Carlow/Kilkenny/South Tipperary Mental Health Services dated 30 May 2014

Communication

The Targeted Intervention Team concluded that there were inconsistencies in the level and quality of communication between service users, families, carers and the service. The Targeted Intervention Team found that in some cases the communication was good, while in other cases it was not.

Rate of Apparent Suicide

The Targeted Intervention Team has no basis for suggesting that the rate of apparent patient suicide in the Carlow/Kilkenny/South Tipperary catchment area during the period under review was anomalous. There were 13 patient deaths by apparent suicide in Carlow/Kilkenny/South Tipperary over a 27 month period. This was a rate of 2.42 apparent patient suicides per 100,000 population. In the United Kingdom there is a Confidential Inquiry into Patient Suicides and Homicides by people with mental illness. The 2014 report from this inquiry states that in England that there are 1248 patient suicides on average per year (Appleby 2014), which equates to a rate of 2.35 patient suicides per 100,000 population. There is no comparable mechanism in Ireland for the collection and analysis of such data.

PART 13: RECOMMENDATIONS

1. Assessment of suicidality should be carried out at each clinical evaluation of mental state. This should be evaluated by audit on a regular basis.
2. Service users should have a risk assessment which leads to a clearly articulated and implemented risk management plan. Risk assessments should be updated at the transitional stages of the care pathway. This should be evaluated by audit on a regular basis.
3. Training in assessment and management of risk should take place to build a culture of patient safety.
4. Heads of discipline should ensure the supervision of clinical staff who carry out risk assessments, to support a good standard of practice.
5. A full and comprehensive admission assessment by NCHDs should be carried out and documented in the clinical file, for all service users who are admitted to the service. This should be evaluated by audit on a regular basis.
6. The Home Based Treatment Team should be consultant-led, be multidisciplinary and should include a dedicated NCHD.
7. HBTT staff should not be redeployed from the teams in order to staff the Department of Psychiatry.
8. Where an external review of serious untoward incidents and sudden unexpected deaths is indicated this should be completed in a timely manner.
9. All sudden unexpected deaths and serious untoward incidents should be followed by a review by the multidisciplinary team with responsibility for the care of the service user. This does not preclude a systems review by the HSE where indicated.
10. Consultant psychiatrists should be included in the internal review process of sudden unexpected deaths and sudden untoward incidents, as appropriate.
11. Consultant psychiatrists should engage with all governance processes.
12. The Executive Management Team should disseminate reports of internal and external reviews of SUIs and SUDs through an appropriate clinical governance forum.
13. The service should actively seek to appoint senior clinical personnel to permanent positions.
14. Policies on clinical and operational procedures should be standardised across the whole Carlow/Kilkenny/South Tipperary area.
15. All multidisciplinary teams should be fully staffed with medical, nursing and health and social care professionals.
16. A Child and Adolescent Mental Health Service must be provided to 16 and 17 year olds in the South Tipperary area in accordance with national policy.
17. A second CAMHS consultant psychiatrist and team should be appointed to the South Tipperary area.
18. Family members should, with the service user's consent, have appropriate and timely communication with members of the treating team.
19. The transfer of service users from the Department of Psychiatry to other residential facilities to vacate beds for admissions should not take place.

PART 14: IMPLEMENTATION PLAN

14.1 Mental Health Commission Policy on Handling Complaints or Concerns about Quality, Safety or Welfare in Mental Health Services

Section 8.12.4 Stage 1 of the Mental Health Commission Policy on Handling Complaints or Concerns about Quality, Safety or Welfare in Mental Health Services (known as the Policy) states as follows:

(i) The targeted intervention team shall initially investigate the matter at issue and establish the relevant facts;

(ii) The targeted intervention team will make recommendations to the mental health service's senior management on how to address the quality, safety or welfare issues that have been identified and/or how to achieve compliance with the relevant provisions of the Regulations, Rules or code/s of practice that it is not compliant with.

(iii) The mental health service's senior management must produce a draft Implementation Plan which indicates how it will address the issues identified, indicate relevant timelines and the persons responsible for ensuring the implementation plan is adhered to and outcomes achieved.

Having investigated the issues in the Carlow/Kilkenny/South Tipperary Mental Health Services, the Targeted Intervention Team made a number of recommendations to the service.

As per section 8.12.4 Stage 1 (iii) of the policy, the service produced an Implementation Plan indicating how it would address the issues identified by the Targeted Intervention Team. This implementation plan was submitted to the Mental Health Commission on 9 April 2015 and was accepted by the MHC at its board meeting on 24 April 2015.

14.2 Inspection of Implementation Plan

An inspection team from the MHC carried out a focused inspection of the Carlow/Kilkenny/South Tipperary Mental Health Services from 5-8 May 2015 (incl.) to determine whether the implementation plan had been carried out. During the course of this inspection, the inspection team met with the Clinical Director, the Area Manager, the Director of Nursing and the Risk Manager.

Site visits were held in the two crisis houses, Glenville and Greenbanks, as well as in the HBTT offices in Carlow, Kilkenny and South Tipperary. The inspection process also included a review of policies, individual service users' clinical files, staffing roster, a review of minutes of various governance meetings, Incident and Near Miss Report books, a review of the programme of supervision for each of the medical, nursing and health and social care professional disciplines and a review of the current status of the reviews (both external and internal) of the service user deaths in the service from January 2012 to March 2014.

On completion of the inspection report on the Implementation Plan, the report was forwarded to the Carlow/Kilkenny/South Tipperary services for factual corrections and was returned on 22 May 2015.

There were two suggested factual corrections to the report and these were accepted by the inspection team.

14.3 Implementation Plan from the Carlow/Kilkenny/South Tipperary Mental Health Services

The Implementation Plan, along with the findings of the inspection report, is detailed below.

Column 1-5 contains the information provided by the service, in response to the individual recommendations.

Columns 6 and 7 contain the findings of the inspection team and the outcome.

Report of the Mental Health Commission Inspection of the Local Action Plan/Implementation of the recommendations from the MHC Targeted Intervention within Carlow/Kilkenny/South Tipperary Mental Health Service, 5-8 May 2015

1. Action/ Recommendation	2. Local Action Plan, Implementation	3. Timelines	4. Responsible Persons	5. Outcomes Achieved	6. Assessment of Implementation Plan on Inspection, May 2015	7. Meets Recommendation
Recommendation –Risk						
1. Assessment of suicidality should be carried out at each clinical evaluation of mental state. This should be evaluated by audit on a regular basis	Assessment of suicidality is carried out at each clinical evaluation of mental state through the conducting of mental state exam as part of the clinical review/assessment process. This is audited as part of the audit of the Collaborative Care Plan.	Completed	ECD/Area Director of Nursing/ HOD	Assessment of suicidality is carried out	(i) Assessment of suicidality was conducted at each clinical evaluation of mental state. (ii) It was not audited as part of the Collaborative Care Plan audit.	PARTIAL
2. Service users must have a risk assessment which leads to a clearly articulated and implemented risk management plan. Risk assessments should be updated at the transitional stages of the care pathway. This should be audited on a regular basis	A risk assessment and associated risk management plan is conducted at initial assessment and as clinically indicated throughout the episode of care. This is audited as part of the audit of the Collaborative Care Plan. A sub-group has been established to review the current risk screening/management tool with the co-opting of academic expertise to ensure that the process is quality assured to include a strong evidence base.	Completed	ECD/CD Area Director of Nursing Risk Manager Heads of Disciplines	Sub-group meetings ongoing	(i) Service users had a risk assessment carried out on admission, which included an initial risk management plan. (ii) This was audited as part of the Collaborative Care Plan audit. (iii) Risk was assessed at transitional periods of care, e.g. transfer from acute to sub-acute ward and prior to discharge.	YES
3. Training in assessment and management of risk should take place to build a culture of patient safety.	A local comprehensive evidence based training package on risk management has been devised and is being implemented across the extended catchment throughout 2015. Planning forums have been established to review and progress the changing model of care for acute services across the catchment.	Commence October 2014 and roll-out in progress Ongoing	Risk Manager/ Senior Psychologist EMT	Training in assessment and management of risk is ongoing	(i) A training programme had commenced and a large number of staff were already trained, particularly medical, nursing and social work staff. (ii)The service had a training protocol in place for risk training and the training record confirmed this had taken place. (iii) A risk manager, solely for the mental health services, had been appointed. (iv) A new forum for dealing with incidents, the Quality and Safety Executive Committee (QSEC), had been developed for the purpose of addressing incidents and follow-up.	YES

4. Heads of discipline should ensure the supervision of clinical staff who carry out risk assessments to support a good standard of practice.	Heads of discipline provide supervision to clinical staff who carry out assessments. All supervisory staff will be facilitated to attend training as required	October 2014 and roll-out in progress	ECD/CD Area DON/AHP-HOD	Structures in place - ongoing	There was a system in place for supervision of medical and nursing staff by their respective line managers and this included supervision of risk assessments. There was one to one supervision for NCHDs with their consultant. A Clinical Nurse Specialist (CNS) supervised nursing staff on a monthly/two monthly basis on an individual and group basis. Locum consultants had an induction programme on commencement and a mentoring programme thereafter. The service was implementing the new National Framework for Clinical Supervision guidelines. The psychology, occupational therapy and social work departments each had a regular timetable for supervision.	YES
5. A full and Comprehensive admission assessment by Non Consultant Hospital Doctors (NCHDs) should be carried out and documented in the clinical file, for all service users who are admitted to the service. This should be evaluated by audit on a regular basis.	A full and comprehensive admission assessment is conducted and documented in the clinical file for all service users who are admitted to the service. This is audited as part of the audit of the Collaborative Care Plan.	Complete	Complete		The assessments by non consultant hospital doctors (NCHDs) on the admission documentation were good. Contrary to what was stated in the Implementation Plan, this was not audited as part of the Collaborative Care Plan audit.	PARTIAL

Recommendation: Home Based Treatment Team						
6. The Home Based Treatment Teams (HBTT) should be consultant led and multidisciplinary and include a dedicated NCHD.	The Home Based Treatment Teams have been incorporated into the Community Mental Health Teams and work in an integrated manner as part of teams. The model of care is currently under review. Application for dedicated NCHD will be made in 2015 Service Planning bidding process to facilitate development of the HBTT process.	Dec 2015	ECD/Area Don/GM/SM/ AHP-HODs		(i) HBTT members operated functionally as part of the CMHT. (ii)The service had applied for a full-time NCHD for the HBTT in Kilkenny, but this was pending the recommendations of the planning groups on reconfiguration. (iii)There was one dedicated session weekly from both the consultant and NCHD of the CMHT in ST. (iv) In the KK HBTT, the Senior Registrar provided input on three days per week but the service user was brought to the DOP, rather than seen in their own home. (v) In Carlow, there were two timetabled slots for the NCHD and one session for the consultant to review service users but in the day hospital rather than in their own homes.	YES
7. HBTTs staff should not be redeployed from the teams in order to staff the Department of Psychiatry.	Four nursing WTE have been assigned to support the increased clinical activity and observation levels within the Department of Psychiatry.	Complete	Service Manager/ Area Don/ Adons	This practice has ceased.	In ST, HBTT staff were deployed to other areas of the MHS dependent on 'activity levels', but were not deployed to the DOP in Kilkenny.	YES

Recommendation: Sudden Unexpected Deaths and Serious Untoward Incidents						
8. Where an external review of serious untoward incidents (SUIs) and sudden unexpected deaths (SUDs) is indicated, this should be completed in a timely manner.	A Process is in place for the management of SUIs in line with national policy. Investigating and management of SUDs/SUIs has been mapped and process for investigation is in place in line with Safety Incident Management Policy (2014), Systems Review Policy (2012) and national training. Reassignment of ADON to the post of Risk Manager for CKST Mental Health Service to liaise with the clinical leads in the review process of sudden unexpected deaths has taken place. The Risk Manager has responsibility for the management of the processes regarding all SUD/SUIs. A Tracking template has been devised and is being used to track and report on SUI Investigations. Oversight is by QSEC.	Complete July 2014	SIMT comprising ECD/GM/Risk Manager QSEC	Risk Manager in place since 03 June 2014	(i) Oversight of reviews now rested with QSEC. Tracking of timelines was kept by the risk manager. (ii) Eleven reviews of the 13 deaths in the TI report had been completed; the two remaining reviews were due to be completed in June/July 2015.	YES
9. All SUIs and SUDs should be followed by a review by the multidisciplinary team with responsibility for the care of the service user. This does not preclude a systems review by HSE where indicated.	All deaths in-service are communicated using the national template to the National Mental Health Division to correspond with notifications to the MHC. The Clinical Incident reporting system facilitates each SUD/SUI being reviewed and discussed locally by the treating team.	Complete	ECD/Risk Manager/ Clinical Leads	All SUIs and SUDs are discussed locally by the treating team.	It was now routine for the multidisciplinary team (MDT) to discuss incidents. The Incident and Near Miss Report Form documented the MDT review and outcome.	YES

10. Consultant Psychiatrist should be included in the review process of sudden unexpected deaths and serious untoward incidents, as appropriate.	CKST is in compliance with the 2012 HSE Guidelines in relation to Full System Analysis Investigations and the Safety Incident Management Policy (2014). As part of that policy, an initial robust assessment is necessary to determine what form of investigation is required. SUI's are managed by the Quality and Safety Executive Committee (QSEC) and full updates are provided. The Risk Manager for CKST Mental Health Services provides an update in relation to SUI's for the EMT monthly and relevant Consultants bi monthly. As part of QSEC, a process is in place for tracking of recommendations and identifying trends.					
Recommendation-Governance						
11. Consultant Psychiatrists should engage with all governance processes.	The Governance structures have been amended to enhance consultant engagement and representation. ECD and the GM meet with Consultant Psychiatrists. The implementation of the Review of Governance Structures in Carlow/Kilkenny/South Tipperary is ongoing. Oversight of this process is governed by external Review Group	Complete In progress	ECD/GM ECD/GM/Area DON	Consultant Psychiatrists are engaging with governance processes.	(i)The Local Clinical Governance groups were being replaced with Mental Health Forums for each catchment area and included attendance by consultants. (ii) Consultants met with the ECD at the Consultants Meeting in July and August 2014. (iii) Membership of QSEC included the ECD, one CD, two Psychiatry of Old Age consultant psychiatrists and one Child and Adolescent Mental Health Service consultant psychiatrist.	YES

12. The Executive Management Team should disseminate reports of internal and external reviews of SUIs and SUDs through an appropriate governance forum.	In the first instance all sudden deaths are discussed by the Safety Incident Management Team, and assessment to determine if further action is required in line with the Incident Management Policy 2014. All deaths are discussed in full at the QSEC monthly meeting. Incident Management has been incorporated into the Terms of Reference of the QSEC where monthly updates are provided. There is a shared folder set up to disseminate information regarding Quality and Patient Safety including reports from internal and external reviews throughout the system. The process for the management of adverse and near miss incidents has been incorporated into the role of the Risk Manager for CKST Mental Health Services who reports on this matter to the QSEC Committee on an ongoing basis. Reports can be generated by the risk manager for any area of the service as requested and bi-annual reports are generated for the MHC. A discussion paper on the recommendations and the wider implications has been published to the members of QSEC and the EMT as part of future improvements/developments.	Complete Complete Complete Ongoing	SIMT/QSEC	Reports of internal and external reviews of SUIs and SUDs are disseminated thorough the appropriate governance forum.	QSEC now managed all incidents and met monthly. It reported to the EMT monthly and disseminated reports and the Risk Register to all staff via a shared folder on the P drive. However, there were teething problems with providing this access to all staff and there was, therefore, no readily accessible forum for dissemination of reports at this time.	PARTIAL

13. The Service should actively seek to appoint senior clinical personnel to permanent positions.	A recruitment process is in place and CAU forms have been completed in respect of vacant posts. Where an outstanding issue with regards to recruiting exists, the matter is raised via the risk register process. General Adult Consultant posts in Carlow and South Tipperary have been filled on a permanent basis and CAMHS post in South Tipperary is in the process of being filled on permanent basis as the post has been offered.	In Progress	Area Manager/ GM/Service Manager/HR		(i) Minutes of the EMT recorded efforts at recruitment (ii)Ten consultants and nine NCHDs in Waterford/Wexford, C/KK/ST area were agency staff (Dec 2014)	PARTIAL
14. Policies on clinical and operational procedures should be standardised across the whole of Carlow/Kilkenny/south Tipperary	The Policy Committee has finalized the amalgamation of the Carlow/Kilkenny and the South Tipperary Policy Books. Both the electronic system and paper system is the same across it ISA. The policies are available on the 'P drive of the IT system in one folder.	Complete	ECD/ Area DON and Service Manager	Clinical and operational procedures are standardised across Carlow/ Kilkenny/south Tipperary	Not all policies were standardised across the whole catchment area and some policies referred to either South Tipperary only or Carlow/Kilkenny only.	PARTIAL
15. All Multidisciplinary teams should be fully staffed with medical, nursing and health and social care professionals	Annual bids are made through the Service Planning Process to enhance and complete multidisciplinary development	In Progress	EMT		Vacancies remained on some teams and this was documented in EMT minutes.	PARTIAL

Recommendation: Child and Adolescent Mental Health Services						
16. The child and Adolescent Mental Health Service must be provided to 16 and 17 year olds in the South Tipperary area.	Team 2 has been established and is in the process of developing through the recruitment of staff. A locum CAMHS consultant commenced duty on 17th Nov 2014 and is presently in process of being appointed in a permanent capacity. This second team is initially concentrating on the waiting list for 16/17 yr olds and existing 16/17 yr olds already in service	Complete	Area Manager/ ECD/CD/GM/	Child and Adolescent Mental Health Service are provided to 16 and 17 year olds in the South Tipperary area.	A second CAMHS team (Team II) in South Tipperary had commenced assessments of children aged 16 & 17 years, including new referrals; however, the waiting list was still approximately two years. The CAMHS service in South Tipperary was currently area-wide but it was planned to develop two separate sectors.	YES
17. A second CAMHS consultant psychiatrist and team should be appointed to the South Tipperary area				A second CAMHS consultant psychiatrist (locum) and team is in place in the South Tipperary area	A second consultant (currently locum) was in the process of being appointed permanently; a SW, NCHD and CNM2 had also been appointed to this team.	YES

18. Family members should, with the service users consent, have appropriate and timely communication with members of the treating team.	Family members, with the service users consent, are routinely invited to attend meeting so discuss service user's care.	Complete	MDT	Family members, with the service users consent, are communicated with by the treating team	(i)The Clinical Director had held discussions with the consultants about the importance of communication with service users and their families. (ii)The admission document made provision for recording the details of the next of kin and whether the resident wished the team to communicate with them. (iii) Clinical files showed evidence of communication with family members in many, but not all, instances. This included records of collateral history being provided, family meetings, telephone conversations and correspondence. (iv) However, two complaints from family members in relation to poor communication had been received by the service.	PARTIAL
19. The transfer of service users from the Department of Psychiatry to other residential facilities to vacate beds for incoming admissions must not take place.	Adherence to the Admission, Transfer and Discharge Policy is monitored.	Complete	ECD/CD/ Clinical Leads		(i)There was evidence in one clinical file that this practice continued. (ii)The draft minutes of a meeting between consultants and ECD on 29.8.2014 showed that the policy was still to transfer "settled" patients to Waterford DOP to facilitate admission of new patients to DOP Kilkenny. (iii)Staff in Glenville House reported that residents were transferred if a bed was required for a new patient admission to DOP, Kilkenny. (iv)The clinical notes of one resident (dated 29.4.2015) noted that the resident could be transferred to the crisis house, if a bed was needed. (v)By way of a telephone conversation on 8.5.2015, a senior clinician confirmed that the practice of transferring residents from the DOP, Kilkenny to both the DOP, Waterford and the crisis house to vacate a bed for another resident, continued. On the 15th May 2015, the National Director of Mental Health, Health Service Executive confirmed by letter that the practice of transferring residents to community residential facilities for the purpose of vacating beds has now ceased. The implementation of this recommendation will continue to be monitored during the course of future inspections.	NO

14.4 Findings of Inspection of the Implementation Plan

There were 19 recommendations in the draft report of the Targeted Intervention and the following table describes the level of implementation:

Outcome	Number of Recommendations
Completed	11
Partially Completed	7
Not Completed	1*

*See recommendation 19 above

Of the seven '*Partially*' completed recommendations, two related to incomplete audits; two related to difficulties in recruitment of staff; and one each related to communication with families, standardised policies across the service area and ready access to reports of reviews of SUI and SUDs.

The outcome in respect of one recommendation on transfer of residents to create a vacant bed had not been implemented, at the time of the re-inspection.

Stage 3 (ii)

The Carlow/Kilkenny/South Tipperary Mental Health Service has shown a willingness to cooperate fully with the process of the Targeted Intervention and has revised a number of its practices.

Although the service has not fully implemented all the recommendations in the Targeted Intervention draft report, there is evidence that it is continuing to address them.

Conclusion

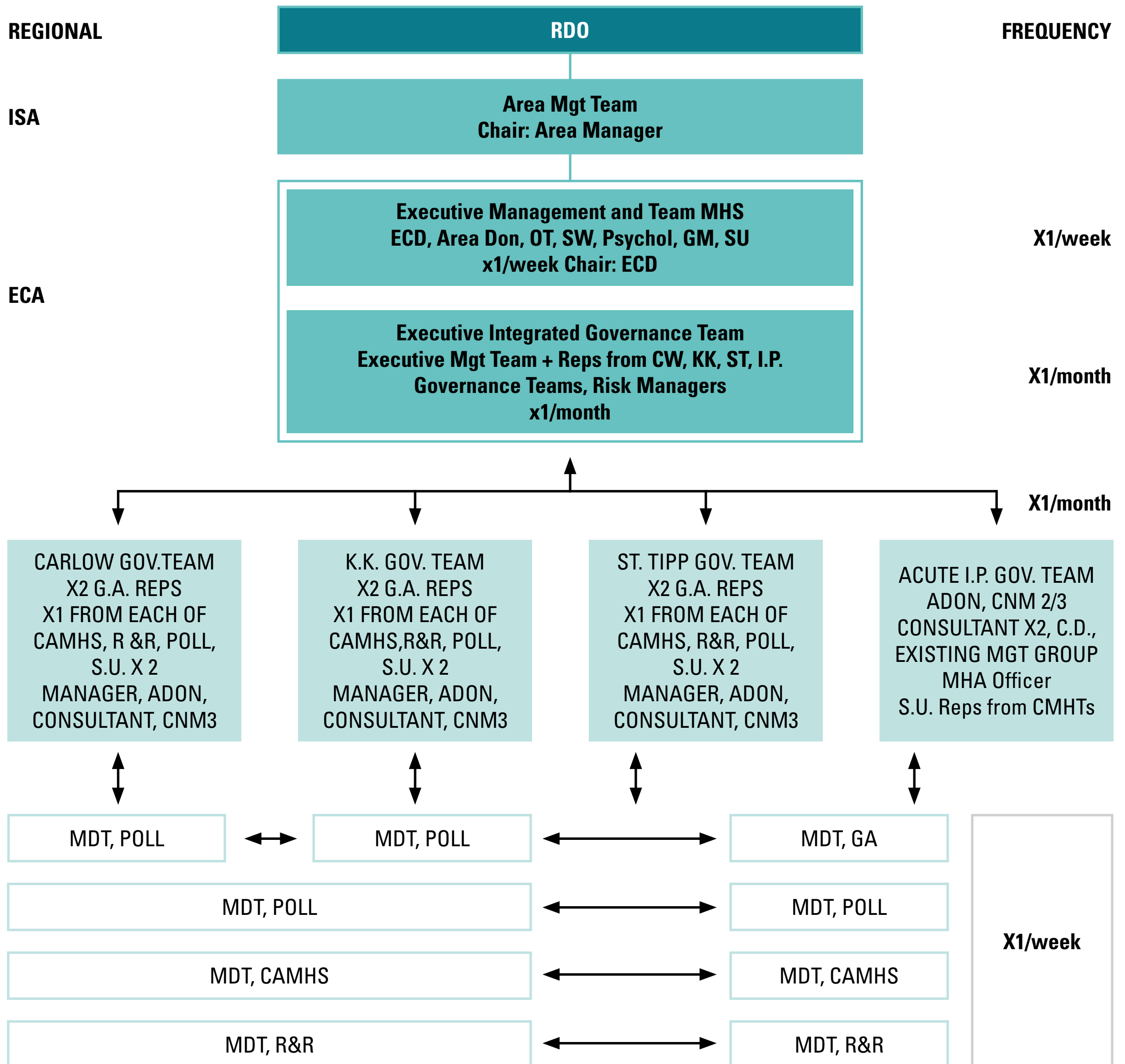
The Targeted Intervention Team recommended that the targeted intervention should be concluded at this time and does not recommend that an inquiry be established in this service.

PART 15: APPENDICES

APPENDIX 1

Dated February 2013

Clinical Governance Structure for Carlow, Kilkenny and South Tipperary Mental Health Services



APPENDIX 2
LIST OF POLICIES, PROCEDURES, PROTOCOLS, GUIDELINES

1. Toolkit of Documentation to Support the Health Services Executive Incident Management approved March 2009
2. HSE South- Carlow/Kilkenny/South Tipperary MHS Governance Framework
3. HSE South – C/K/ST MHS Feedback on Governance Framework and Steering Group Response/Actions updated 20 August 2010
4. Absent Without Official Leave dated March 2012
5. Crisis House Operational Guideline approved April 2012
6. Operational Guidelines for Glenville House approved July 2012
7. Crisis response Out of Hours Protocol approved August 2012
8. HSE Guidelines for Systems Analysis Investigations of Incidents and Complaints approved 16 November 2012
9. Home Based Treatment Guidelines approved February 2013
10. Suicide Review Policy approved March 2013
11. C/K/ST – SUI Pathway dated 5 June 2013
12. DRAFT SUI Notification Policy dated November 2013
13. Discharge Policy effective date January 2014
14. Assistant Director of Nursing Area or Responsibility Table dated March 2014
15. Review of the Governance within Carlow/ Kilkenny/South Tipperary Mental Health Services dated 30 May 2014
16. C/K/ST MHS Local Implementation Plan Review of the Governance Structures dated October 2014
17. Inspector of Mental Health Services Inspection Reports of the Department of Psychiatry, St Luke's Hospital, Kilkenny 2012,2013,2014
18. Inspector of Mental Health Services Catchment Area report of Carlow/Kilkenny Mental Health Services, 2013
19. Minutes of Governance Groups:
    - Acute In-patient Governance Team, 11 January 2013 – 5 March 2014
    - Carlow Mental Health Services Development Working Group, 5 September 2012 – 17 April 2013
    - Carlow Mental Health Services Local Governance Meeting, 22 May 2013 – 13 March 2014
    - Clinical Governance Quality Assurance Forum, South Tipperary, 3 January 2012 – 14 March 2014
    - Executive Management Team Meetings, 23 January 2013 – 13 March 2014
    - Integrated Governance Group, 27 March 2013 – 29 January 2014
    - Carlow/Kilkenny Management Team Meeting, 8 February 2012 – 12 December 2012
    - Kilkenny Local Clinical Governance Group, 16 May 2013 – 20 February 2014

Undated Documents

20. C/K/ST MHS – "Implementing A Vision for Change"
21. HSE C/K/ST MHS Welcome and Information Booklet
22. Initial Screening Assessment Form
23. Short Screening Assessment Form
24. Clinical Governance Structure for Carlow, Kilkenny and South Tipperary Mental Health Services
25. Care planning process
26. Carlow/Kilkenny Sub Catchment Referral Pathway

GLOSSARY

A.M.	AREA MANAGER
AREA D.N.	AREA DIRECTOR OF NURSING
CAMHS	CHILD AND ADOLESCENT MHS
ECA	EXPANDED CATCHMENT AREA
ECD	EXECUTIVE CLINICAL DIRECTOR
GA	GENERAL ADULT
ISA	INTEGRATED SERVICE AREA
MHS	MENTAL HEALTH SERVICE
MDT	MULTIDISCIPLINARY TEAM
POLL	PSYCHIATRY OF LATER LIFE
R&R	REHABILITATION & RECOVERY TEAM
S.U.	SERVICE USER
I.P.	INPATIENT

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