Mental Health Commission finds eight high risk ratings in three mental health centres

High risk non-compliance in staff training at all three approved mental health centres

Thursday 1 August 2019: The Mental Health Commission (MHC) has today published three inspection reports from approved centres in Dublin, Tipperary and Roscommon, which identified eight areas of high risk non-compliance.

Two of the approved centres have a range of quality best practice initiatives highlighted in the inspection reports. The Department of Psychiatry in Roscommon has introduced a smoking cessation group facilitated weekly and Roscommon Sports Partnership runs an exercise group. The Sycamore unit in Connolly Hospital in Blanchardstown has introduced dementia related education sessions for clinical staff, and the O'Casey Rooms in Fairview has introduced the Irish Hospice Foundation's Compassion End of Life (CEOL) programme to improve end of life care for residents and their families.

Commenting on the reports, Dr Susan Finnerty, Inspector of Mental Health Services, said: "It is difficult to understand the geographical disparities that arise in approved centres with poor practices and a steady decrease in compliance in a service in one part of the country and a marked increase in compliance and excellence in another part of the country. This amounts to a form of care injustice within the mental health services for service users. It also points to the importance of good governance in providing a quality service."

The Department of Psychiatry, Connolly Hospital in Blanchardstown has 47 beds and at the time of the inspection, there were 36 residents present. Seven consultant led teams admitted residents to the approved centre as well as two rehabilitation teams and a team providing mental health services for the homeless population. Compliance with regulations had steadily decreased over the past three years from 66% in 2017 to 63% in 2018 and to 56% in this 2019 inspection The DOP in Connolly Hospital has been non-compliant with eight regulations for three consecutive years. Six compliances with regulations were rated as excellent.

There were two conditions attached to the registration of the centre; requiring continuous auditing of individual care plans and implementing a plan to ensure healthcare professionals receive up to date mandatory training and the centre was non-compliant with both regulations on this inspection.

At the time of inspection, the centre had six high risk non-compliances for individual care planning, general health, privacy, maintenance of records, prescribing storing and administration of medicines and the use of physical restraint.

Despite a condition to their registration to ensure compliance the development of individual care plans was inadequate. In four cases, care plans were not developed by the multi-disciplinary team. In a number of cases, there was no documentary evidence that the resident had been involved in the development of the ICP or in a weekly review of the ICP. In a number of cases, there was no evidence that the resident had been offered a copy of their ICP. In four ICPs reviewed, there was a

failure to document appropriate goals and the resources required to achieve the goals specified were not indicated in three ICPs reviewed. Additionally care plans were not consistently updated.

There were serious breaches of privacy with noticeboards in the nurse's station in both units displaying resident names and other information. These boards were visible through glass panelling from outside the nurse's station. During the course of the inspection, a list of resident names was observed in the reception area of the unit which was accessible to visitors and non-clinical staff. CCTV cameras, which were located within corridor areas of the centre which were accessed by residents, were capable of recording or storing a resident's image. Monitors in the nursing office were viewable by residents and members of the public.

Since the inspection the Mental Health Commission's preventative and corrective actions has ensured that notice boards have all been replaced with "fold over notice boards" which conceal resident information from members of public

There were two breaches of human rights evident in the approved centre at the time of inspection. The staff did not adhere to the code of practice when a resident was physically restrained. In one case, a staff member was not designated to be responsible for leading the physical restraint and monitoring the head and airway of the resident. In no case did a registered medical professional complete a medical examination within three hours of the end of the episode. In two cases, residents were not informed of reasons for, likely duration of, or circumstances leading to discontinuation. In no case was there evidence that each episode was reviewed by members of the multi-disciplinary team and documented within two working days and there was no written record to indicate that staff involved in the use of physical restraint had read and understood the policy.

The Department of Psychiatry, Roscommon University Hospital, is registered for 22 residents, but there were 23 residents in the approved centre on the first day of the inspection. This had occurred on four other occasions since 1 January 2019. Despite being registered for 22 beds, there are 28 beds in the approved centre.

Since 2017, when there was a compliance rate of 46% with regulations, rules and codes of practice, enormous efforts by management and staff had been put into increasing compliance and quality of care and treatment given. In 2018, the compliance rating increased to 79% and there was again an improvement in 2019 to 88%. There were 14 compliances rated as excellent, increased from 11 in 2018.

The centre had two high risk ratings of non-compliance for premises and use of physical restraint.

There was one condition attached to the registration of this approved centre at the time of inspection relating to privacy and premises. The centre was non-compliant with premises at the time of inspection. It was compliant with the regulation privacy.

In relation to the high risk non-compliance on premises, hazards, including large open spaces, slippery floors, and hard and sharp edges, were not minimised in the approved centre. The shower tray in the high dependency unit bathroom was an identified slip, trip and fall risk. The second phase of anti-ligature works had not commenced and ligature points were not minimised to the lowest practicable levels.

Since the inspection a firm of architects have visited and conducted an assessment. They have been funded to complete design plans for phase two of window upgrade to anti-ligature standard. The upgrade will also include all bathrooms and showers to the highest level of anti-ligature standard. The

provision of a new front door is also included in the plans. The Mental Health Commission believe these plans are achievable but are subject to approval of Capital Funding by HSE.

Following the annual inspection of **Haywood Lodge Clonmel Co Tipperary,** a 40 bed in-patient unit. 24 – 27 July and 2 - 3 August 2018, the Director of Standards and Quality Assurance was alerted by the Inspector to serious concerns about critical risk ratings of non-compliances with therapeutic services and programmes. An immediate Action Notice was issued and the service provided a plan and further information to address the Commission's concerns, its implementation was monitored by way of a focused inspection.

During this inspection, the Inspector found that the approved centre now provided therapeutic services and programmes for all residents. Each resident's needs had been assessed and a comprehensive individual therapy plan was in place for each resident. There was an activities nurse for both units who provided a wide range of both recreational and therapeutic programmes. This included chair yoga, Sonas, relaxation, reminiscence therapy and cookery. There was also individual one to one therapy.

An occupational therapist was in place, shared between East House and West House. A music therapist had provided a ten week programme and there were plans to continue this arrangement. An artist attended two hours a week. A psychologist provided support and behavioural therapy assessments and recommends intervention strategies for residents as clinically indicated. Two days training in Dementia Care had taken place for staff and was ongoing.

Mr. John Farrelly, Chief Executive Mental Health Commission, said: "We cannot ignore the fact that not everyone is getting good care. It cannot be right that people's care depends on where they live or the type of support they need. There were failures in clinical governance in one of the approved centres where compliance with regulatory requirements showed continued dis-improvement. There was no evidence that this was considered a serious risk or that actions were in place to address this. Governance is an area of serious concern to the Commission and there is no excuse for not having good governance in place, especially when addressing it would immediately improve the service for patients"

ENDS

For the Editor

Inspection Reports

1. **Department of Psychiatry, Connolly Hospital**
   https://www.mhcirl.ie/File/2019IRs/DOPConnolly_IR2019.pdf

The Department of Psychiatry (DOP) has 47 beds and is located on the lower ground floor of Connolly Hospital building. The approved centre provides acute in-patient accommodation for the Dublin North City area from Cabra to Mulhuddart. The approved centre is part of the Dublin North City and County Healthcare Organisation (previously CHO 9). Seven consultant led teams admit residents to the approved centre as well as two rehabilitation teams and a team providing mental health services for the homeless population.
There were two conditions attached to the registration of this approved centre at the time of inspection.

Condition 1: *To ensure adherence to Regulation 15: Individual Care Plan, the approved centre shall audit their individual care plans on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.*

Condition 2*: To ensure adherence to Regulation 26(4): Staffing the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission*.

Non-compliant areas on this inspection:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Regulation 13: Searches	✓		✗	Moderate	✗	Moderate
Regulation 15: Individual Care Plan	✗	High	✗	High	✗	High
Regulation 16: Therapeutic Services and Programmes	✓		✓		✗	Moderate
Regulation 19: General Health	✓		✗	High	✗	High
Regulation 21: Privacy	✓		✗	Moderate	✗	High
Regulation 22: Premises	✗	Moderate	✗	High	✗	Low
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✗	High	✗	Moderate	✗	High
Regulation 25: Use of Closed Circuit Television	✓		✓		✗	Low
Regulation 26: Staffing	✗	Moderate	✗	Moderate	✗	Moderate
Regulation 27: Maintenance of Records	✗	High	✗	High	✗	High
Rules Governing the Use of Seclusion	✗	Moderate	✗	Critical	✗	Low
Code of Practice on the Use of Physical Restraint in Approved Centres	✓		✗	Critical	✗	High
Code of Practice Relating to the Admission of Children	✗	Moderate	✗	Moderate	✗	Moderate
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	✗	Low	✗	Moderate	✗	Moderate

The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance. These are included in **Appendix 1** of the report.

Areas of compliance rated "excellent" on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 7: Clothing

Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 30: Mental Health Tribunals

2. Department of Psychiatry, Roscommon University Hospital

https://www.mhcirl.ie/File/2019IRs/DOPRoscommon_IR2019.pdf

The approved centre is an acute admission unit located in Roscommon University Hospital. It is on the ground floor and occupies what had formerly been the maternity ward and is, therefore, not purpose-built. Although registered for 22 residents, there were 23 residents in the approved centre on the first day of the inspection. This has occurred on four other occasions since 1 January 2019.
Four sector teams has admitted to the approved centre. These comprised Roscommon, Ballinasloe, Portumna, Mountbellew, Glenamaddy and Athlone regions of Galway Roscommon mental health services. The Rehabilitation and Recovery team and the Psychiatry of Later Life also have admitting privileges.

There was one condition attached to the registration of this approved centre at the time of inspection.

Condition 1: *To ensure adherence to Regulation 21: Privacy and Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update to the Mental Health Commission on the programme of maintenance in a form and frequency prescribed by the Commission.*

Non-compliant areas on this inspection:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Regulation 22: Premises	✗	High	✗	High	✗	High
Regulation 26: Staffing	✗	Moderate	✗	High	✗	Moderate
Regulation 27: Maintenance of Records	✗	Low	✓		✗	Moderate
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	Moderate	✗	Moderate	✗	High

The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance. These are included in **Appendix 1** of the report.

The following areas were rated excellent on this inspection:

Regulation
Regulation 5: Food and Nutrition
Regulation 6: Food Safety
Regulation 7: Clothing

Regulation 8: Residents' Personal Property and Possessions
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 12: Communication
Regulation 13: Searches
Regulation 16: Therapeutic Services and Programmes
Regulation 18: Transfer of Residents
Regulation 19: General Health
Regulation 29: Operating Policies and Procedures
Regulation 30: Mental Health Tribunals

3. **Haywood Lodge, Clonmel, Co.Tipperary**
   https://www.mhcirl.ie/File/2018IRs/HaywoodLodgeFocInspec_2019.pdf

Haywood Lodge is a single-storey building situated off the Haywood Road in Clonmel, County Tipperary. The 40 bed in-patient unit is located within close proximity to South Tipperary General Hospital. The approved centre consists of two units, which caters for Psychiatry of Later Life (East House), and Rehabilitation and Recovery (West House).
During the annual inspection of Haywood Lodge on 24 - 27 July and 2 - 3 August 2018, the approved centre was found non-compliant with Regulation 16: Therapeutic Services and Programmes and this non-compliance was risk rated as critical.

Following an immediate action notice issued to the registered proprietor, a focused inspection took place to assess whether the approved centre was compliant with Regulation 16 Therapeutic Services and Programmes.

During this inspection the approved centre was found to be compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

(1) The registered proprietor shall ensure that each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan.

(2) The registered proprietor shall ensure that programmes and services provided shall be directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident.

During this inspection, the Inspector found that the approved centre now provided therapeutic services and programmes for all residents. Each resident's needs had been assessed and a comprehensive individual therapy plan was in place for each resident. There was an activities nurse for both units who provided a wide range of both recreational and therapeutic programmes for the residents. Therapeutic services and programmes provided included chair yoga, Sonas, relaxation, reminiscence therapy and cookery. There was also individual one to one therapy.

An occupational therapist was in place, shared between East House and West House. A music therapist had provided a ten week programme and there were plans to continue this arrangement. An artist attended two hours a week. A psychologist provided support and behavioural therapy assessments and recommends intervention strategies for residents as clinically indicated. Two days training in Dementia Care had taken place for staff and was ongoing.

The approved centre was compliant with this regulation.

About the Mental Health Commission:

The Mental Health Commission is an independent statutory body. The primary functions of the Mental Health Commission are to foster and promote high standards of care and good practice in the delivery of mental health services and to ensure that the interests of those involuntarily admitted are protected, pursuant to the Mental Health Act 2001.

Approved Centres:

A 'centre' is "a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder" (Mental Health Act 2001)

To operate an in-patient mental health service in Ireland, the service must be registered as an 'approved centre' with the Mental Health Commission. Each centre must re-register for approval every 3 years.

Upon registration, the service must comply with regulations made under the Mental Health Act 2001. Failure to comply with regulations may result in enforcement action including: corrective and preventative action plans, an immediate action notice, a regulatory compliance meeting, registration conditions, removal from the register (closure) and prosecution.

MHC inspection process:

There are 39 areas in the inspection process of approved mental health centres. Each approved centre is assessed against a suite of regulations, rules, and codes of practice.

Inspectors, over a three day period, use a combination of documentation review, observation and interview to assess compliance. The Inspection team

- speak with residents to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell them,

- review documents to see if appropriate records are kept, that they reflect practice, in line with the standards and are what people tell them.

Areas of inspection are deemed either compliant or non-compliant. Where areas are considered non-compliant, this is risk rated. Risk measurements are rated as low, moderate, high or critical.

Following the inspection, the Inspector prepares a report on the findings. A draft of the report is furnished to the registered proprietor of the approved centre, and includes provisional compliance ratings, risk ratings and quality assessments.

The registered proprietor is provided with an opportunity to review the draft and comment on any of the content or findings. The Inspector takes into account the comments by the registered proprietor and amends the report as appropriate.

Following this, the registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance addressing the specific non-compliances identified.

The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

Enforcement and monitoring processes
The Commission has a range of powers in relation to monitoring compliance of approved centres and where necessary, taking enforcement action.

The Commission will generally request a **corrective and preventative action** (CAPA) plan in the first instance and work with the service to address the concern. A CAPA plan must specifically address the non-compliance and put measures in place to prevent recurrence.

The Commission may issue an **Immediate Action Notice** where a concern needs to be addressed urgently.

The Commission can also direct services to attend a **Regulatory Compliance Meeting** at the Commission offices where they must provide evidence that they are implementing plans to address the concern. Where the Commission is not satisfied with plans provided, then the matter will be escalated.

The Commission may attach **conditions** to an approved centre's registration (similar to a penalty or endorsement on a driver licence). It is an offence to breach a condition of registration.
Where the Commission has ongoing and serious concerns about the care and treatment provided by an approved centre then it may **remove the service from the register**. This in effect means the closure of the approved centre.

Finally, there are a number of offences under the Act including offences relating to the failure or refusal to comply with the provision of the regulations. The Commission may decide to **prosecute** a service in relation to very serious and ongoing concerns.