Department of Psychiatry, Connolly Hospital

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mental health commission

Focused Inspection
Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

DEPARTMENT OF PSYCHIATRY, CONNOLLY HOSPITAL

Date of Publication: 1st May 2024

ID Number: AC0133

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care

Conditions Attached:
Yes

Most Recent Registration Date:
7 December 2021

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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Inspection Date:
14 March 2023

Previous Inspection date:
18 – 21 October 2022

Inspection Type:
Unannounced Focused Inspection

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1.0 Introduction

1.1 Summary

This focused inspection took place following receipt of a submitted issue of concern in the form of a letter from an unidentified past resident of the Department of Psychiatry Connolly Hospital. The following findings were made on inspection:

Property and Possessions: Secure facilities were not provided for the safe keeping of all resident property and possessions and residents clothes were observed in shopping bags on the floor and on chairs beside beds.

Recreational activities: The approved centre did not provide a full range of television channels appropriate to the resident group profile. There was no access to national channels and therefore no access to national sporting events or national current affairs.

Therapeutic services and Programmes: Not all residents referred to the psychology service were assessed or treated prior to discharge from the approved centre, although there were two full-time psychology staff based in the approved centre. Any resident who had been referred to psychology and not seen was referred to psychology in the community team. However, the waiting list in the community was ten to twelve months.

Privacy and Dignity: There were a number of issues that showed that privacy and dignity were not always respected in the approved centre: Not all shared rooms in the approved centre had bed screening. Observation panels on bedroom doors were not adequately fitted to ensure resident dignity and privacy. Privacy panels on bedroom doors were observed to be in an open position and residents were unable to close the privacy panel from inside their bedrooms. Three privacy panels on bedroom doors in the High Dependency Unit were broken and in an open position.

Premises: There were numerous cigarette butts in the main courtyard, bedrooms in the approved centre were not adequately ventilated as none of the bedroom windows could be opened, a number of bedrooms did not have a refuse bin for residents' use. Hazards were not minimised as the path in the occupational therapy garden had missing and loose bricks. There was a sharp metal edge on the curb that lined a small plant area in the garden of the High Dependency Unit. Communal rooms in Ash and Pine Ward were inadequately sized to accommodate the needs of residents.

1.2 Background

This focused inspection took place following receipt of a submitted issue of concern in the form of a letter from an unidentified past resident of the Department of Psychiatry Connolly Hospital. The letter outlined concerns in relation to the following areas:

- The ward not being fit for purpose.
- Residents moved a number of times during their admission, which included sharing a room with other residents.
- Flies, coming through cracks in the wall.
- No counselling or therapist available.
- Isolation in bedroom with no recreational or therapeutic intervention during admission.
- Television channels which could not be changed.
- Windows that did not open.
- Yard time restricted to certain times, otherwise locked.
- Unprofessional behaviour by staff, to include laughing and mocking of residents, and being called by another resident's name.
- Ward being unsafe due to intimidating behaviour of residents.
- No referral to therapies on discharge.

1.3 Reason for focused inspection

The reason for this focused inspection was to examine in detail the following regulations: Regulation 9: Recreational Activities, Regulation 16: Therapeutic Services and Programmes, Regulation 21: Privacy, Regulation 22: Premises, and the Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, specifically discharge.

While in the approved centre it became apparent during inspection that Regulation 8: Personal Property & Possessions was also applicable to this inspection.

2.0 Overview of the Approved Centre

2.1 Description of the Approved Centre

The Department of Psychiatry (DOP) was located on the lower ground floor of Connolly Hospital in Blanchardstown. Entrance was from the ground floor via a staircase. The approved centre was part of the Dublin North City and County Healthcare Organisation and provided acute in-patient accommodation for the Dublin north city and county area. Nine consultant led teams based in four catchment areas in Blanchardstown east and west, Finglas and Cabra, admitted residents to the approved centre. Two rehabilitation teams and a team dealing with the homeless population, also admitted to the centre.

The DOP comprised of a long reception corridor with adjacent offices, a tribunal room, and a family visiting room. The Occupational Therapy Department was located through double doors at the end of the reception corridor. Resident accommodation was on two wards, Ash Ward and Pine Ward, both located off the reception corridor. Entrance to a High Dependency Unit (HDU) with accommodation for up to five residents, and which incorporated a seclusion room, was accessed via Ash Ward or through a separate external entrance.

Both Ash and Pine Wards had accommodation for 21 residents each. Resident accommodation on both Ash and Pine Wards consisted of a mix of three single rooms, two with en suite bathrooms, three double rooms, with ensuite bathrooms, and three four-bedded rooms. There was a large, paved courtyard which was used by both wards. The day rooms on both Ash and Pine Wards were small. A multi-purpose area at the entry point to the courtyard on Ash Ward and a quiet room provided further communal space on Ash Ward.

The number of registered beds was 47. The total number of residents in the approved centre on the day of inspection was 42.

3.0 Methodology

The inspection team examined the clinical files of 10 residents, the complaints log, community meeting minutes, maintenance log and spoke with seven residents and a member of the Senior Management Team.

The Inspection Team examined the following regulations:

Regulation 8: Personal Property and Possessions.
Regulation 9: Recreational Activities.
Regulation 16 Therapeutic Services and Programmes.
Regulation 21: Privacy.
Regulation 22: Premises.
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, specifically discharge.

4.0 Inspection Findings

EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)

Regulation 8: Residents' Personal Property and Possessions

NON-COMPLIANT

Risk Rating HIGH

(1) For the purpose of this regulation "personal property and possessions" means the belongings and personal effects that a resident brings into an approved centre; items purchased by or on behalf of a resident during his or her stay in an approved centre; and items and monies received by the resident during his or her stay in an approved centre.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures relating to residents' personal property and possessions.

(3) The registered proprietor shall ensure that a record is maintained of each resident's personal property and possessions and is available to the resident in accordance with the approved centre's written policy.

(4) The registered proprietor shall ensure that records relating to a resident's personal property and possessions are kept separately from the resident's individual care plan.

(5) The registered proprietor shall ensure that each resident retains control of his or her personal property and possessions except under circumstances where this poses a danger to the resident or others as indicated by the resident's individual care plan.

(6) The registered proprietor shall ensure that provision is made for the safe-keeping of all personal property and possessions.

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in October 2022. Secure facilities were not provided for the safe keeping of all resident property and possessions. On inspection, clothes were observed in shopping bags on the floor and on chairs beside beds.

On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. The checklist was updated on an ongoing basis, in line with the approved centre's policy. The property checklist was kept separately to the resident's individual care plan (ICP) and was available to the resident. Not all residents were supported to manage their own property, as:

- Some residents did not have lockers.
- Some residents did not have wardrobes.
- Some residents did not have wardrobes or lockers.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that provision was made for the safe-keeping of all personal property and possessions, as residents' property was on the ground in shopping bags or on chairs in a number of bedrooms. Some residents had no lockers, some residents had no wardrobes, and some had neither, 8 (6).

Regulation 9: Recreational Activities

NON-COMPLIANT

Risk Rating LOW

The registered proprietor shall ensure that an approved centre, insofar as is practicable, provides access for residents to appropriate recreational activities.

INSPECTION FINDINGS

The approved centre did not ensure, insofar as practicable, that residents were provided with access to appropriate recreational activities. The approved centre did not provide a full range of television channels appropriate to the resident group profile. There was no access to national channels, similar to the wider acute hospital, and therefore no access to national sporting events or national current affairs.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure, insofar as practicable, that residents had access to appropriate recreational activities, as there was not a full range of television channels appropriate and available to the resident group profile.

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating MODERATE

(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.

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as detailed in their individual care plans (ICPs). The approved centre had a therapy department where both the occupational therapy (OT) and psychology offices were based. Therapeutic rooms included the OT kitchen, OT garden, the 'My Space Room' (used for relaxation), a recreation room (including interactive whiteboard), and an arts and crafts room. There were four full-time OT staff in the approved centre: one senior, two staff grades, and one occupational therapy assistant.

Residents were seen on an individual and group basis. Groups were held in the therapy department, and group themes changed on a weekly basis depending on resident feedback and the assessed needs and goals of the residents. On the week of inspection, themes included a knitting group, a novel experiences group, and a St. Patrick's Day-themed group. There was one recurring exercise group held every week. Psychology group focusing on coping with emotions, building distress tolerance and self-compassion was held weekly, a referral was not required. There were two groups held in the High Dependency Unit on a weekly basis: an exercise group and a leisure-based group whose weekly content was chosen by the residents. Social workers were based in the community and offered an in-reach service to the approved centre. All admitting teams had a social worker attached, and social workers attended the multi-disciplinary team (MDT) meetings.

The therapeutic services and programmes in the approved centre did not provide optimal levels of psychosocial functioning for the residents, as not all residents referred to the psychology service were assessed or treated prior to discharge from the approved centre. There were two full-time psychology staff based in the approved centre (one senior and one staff grade). According to data reviewed on inspection, for the period from the 15th of February in 2022 to the same date in 2023, 51 residents had been discharged without having been seen by psychology. (It was noted that since 2019, 30% of the referrals who were discharged unseen was due to 'quick turnaround of referrals.') In the event that a referred resident was not seen prior to discharge, this person was referred to psychology in the community team. At the time of inspection, the waiting list in the community was ten to twelve months.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that services provided were directed towards restoring and maintaining optimal levels of psychosocial function of each resident, as not all residents referred to the psychology service were assessed or treated prior to discharge from the approved centre, 16 (2).

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating HIGH

The registered proprietor shall ensure that the resident's privacy and dignity is appropriately respected at all times.

INSPECTION FINDINGS

The general demeanour of the staff in the approved centre was appropriate to and supportive of the dignity and privacy of the residents. Residents were called by their preferred names, staff appearance and dress was appropriate, and staff showed discretion when discussing the resident's condition or treatment needs. Staff sought the resident's permission before entering their room, as appropriate.

The inspection team spoke to seven residents. Feedback was positive towards staff and no concerns were expressed in relation to intimidating or unprofessional behaviour by staff. Residents reported that a peer to peer assault had occurred in the approved centre on the previous day. There had also been an assault on a member of staff on another occasion prior to that. Six residents interviewed said they felt safe, one said they did not feel safe. Residents and staff had to contend with intimidating and frightening behaviours at times. Residents said they had access to the courtyard throughout the day.

All bathrooms, showers, and toilets had locks on the inside of the door, except in the case of an identified risk to the resident. Not all shared rooms in the approved centre had bed screening which ensured resident privacy. Privacy screening in one double room was absent and awaiting replacement at the time of inspection. Observation panels on bedroom doors were not adequately fitted to ensure resident dignity and privacy. Privacy panels on bedroom doors were observed to be in an open position. Residents were unable to close the privacy panel from inside their bedrooms. Three privacy panels on bedroom doors in the High Dependency Unit were broken and in an open position.

Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make private calls.

The approved centre was non-compliant with this regulation for the following reasons:

a) **The registered proprietor did not ensure that the resident's privacy and dignity was respected at all times, as handles positioned on external aspect of privacy panels on bedroom doors were in an open position. Residents could not close the privacy panel from inside their bedrooms. Some privacy panels did not have handles and therefore remained open.**

b) The registered proprietor did not ensure that the resident's privacy and dignity was respected at all times because privacy screening in one double bedroom was absent.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

(a) premises are clean and maintained in good structural and decorative condition;

(b) premises are adequately lit, heated and ventilated;

(c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

(2) The registered proprietor shall ensure that an approved centre has adequate and suitable furnishings having regard to the number and mix of residents in the approved centre.

(3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff and visitors.

(4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose in so far as it practicable and in accordance with best contemporary practice.

(5) Any approved centre in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall ensure that the buildings are, as far as practicable, accessible to persons with disabilities.

(6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and 2001, Part M of the Building Regulations 1997, the Disability Act 2005 and the Planning and Development Act 2000.

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space. However, appropriately sized communal rooms were not provided: the communal rooms in Ash and Pine Ward were inadequately sized to accommodate the needs of the residents. There was suitable and sufficient heating in day areas and in bedrooms. Bedrooms were not adequately ventilated as none of the bedroom windows could be opened. Private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

Sufficient spaces were provided for residents to move about, including outdoor spaces. All health and safety hazards had not been minimized in the approved centre. The path in the occupational therapy garden had missing and loose bricks and there was a sharp metal edge on the curb that lined a small plant area in the garden of the High Dependency Unit. Ligature points were minimised to the lowest practicable level, based on risk assessment.

The approved centre was not kept in good a state of repair internally in that there were no doors on the cupboard in the day room of the High Dependency Unit. Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. There was no evidence of previous or present insect or fly infestation. The approved centre was not clean and hygienic in that there were numerous cigarette butts in the main courtyard. Current national infection control guidelines were followed.

The approved centre provided a sufficient number of toilets and showers for residents, with at least one assisted toilet per floor. There was a designated cleaning room and sluice room, and the centre provided assistive devices and equipment to address resident needs. All resident bedrooms were appropriately sized to address the resident needs. The approved centre did not provide suitable furnishings to support resident independence and comfort in that a number of bedrooms did not have a refuse bin for residents' use.

The approved centre was non-compliant with this regulation for the following reasons:

a) **The approved centre was not kept in a good state of repair internally as there were no doors on the cupboard in the day room of the High Dependency Unit, 22 (1)(a).**
b) **The approved centre was not clean and hygienic as there were numerous cigarette butts in the main courtyard, 22 (1)(a).**
c) **Bedrooms in the approved centre were not adequately ventilated as none of the bedroom windows could be opened, 22 (1)(b).**
d) **The registered proprietor did not ensure that the approved centre had adequate and suitable furnishings, as a number of bedrooms did not have a refuse bin for residents' use, 22 (2).**
e) **Hazards were not minimised as the path in the occupational therapy garden had missing and loose bricks. There was a sharp metal edge on the curb that lined a small plant area in the garden of the High Dependency Unit, 22 (3).**
f) **Communal rooms in Ash and Pine Ward were inadequately sized to accommodate the needs of residents, 22 (3).**

5.0 Inspection Findings – Codes of Practice

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

Section 33(3)(e) of the Mental Health Act 2001 requires the Commission to: "prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services".

The Mental Health Act, 2001 ("the Act") does not impose a legal duty on persons working in the mental health services to comply with codes of practice, except where a legal provision from primary legislation, regulations or rules is directly referred to in the code. Best practice however requires that codes of practice be followed to ensure that the Act is implemented consistently by persons working in the mental health services. A failure to implement or follow this Code could be referred to during the course of legal proceedings.

Please refer to the Mental Health Commission Codes of Practice, for further guidance for compliance in relation to each code.

Admission, Transfer and Discharge

COMPLIANT

Please refer to the Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge. This inspection focused on the discharge process only.

Discharge: The discharge policy, which was last reviewed in May 2021, included all of the policy-related criteria for this code of practice.

Evidence of Implementation:

Admission:
Following admission, residents can be relocated from a single room to a shared room, depending on clinical need, or from Ash ward to Pine ward and vice versa depending on bed availability and resident's catchment area.

The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, reference to early warning signs of relapse and risks, and documented communications with the relevant healthcare provider. The discharge meeting was attended by the resident, key worker, relevant members of the resident's multi-disciplinary team (MDT), and family or representative, where appropriate.

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; social and housing needs; and informational needs. The discharge was coordinated by the key worker. The preliminary discharge summary was sent to the relevant healthcare provider within three days. A comprehensive discharge summary was issued within 14 days.

The discharge summary included details of the following: diagnosis; prognosis; medication; mental state at discharge; outstanding health or social issues; follow-up arrangements; names and contact details of key people for follow-up; and risk issues such as signs of relapse. Family members, carers and advocates were involved in the discharge process, where appropriate. A timely follow-up appointment was made within one week.

The approved centre was compliant with this code of practice.

Appendix 1

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to "visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate".

Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

On a focused inspection, the Inspector does not assess all regulations, rules, code of practice, and Part 4 of the 2001 Act. The focus of the inspection will be on specific legislative requirements, or parts of legislative requirements where it is determined that there may be a risk to the safety, health and well-being of residents and/or staff members.

Following the focused inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings and risk ratings, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.