Acute Mental Health Admission Unit, Kerry General Hospital inspection report 23 June 2010

Report of the Inspector of Mental Health Services 2010

EXECUTIVE CATCHMENT AREA	South Lee/West Cork/Kerry
HSE AREA	South
CATCHMENT AREA	Kerry
MENTAL HEALTH SERVICE	Kerry
APPROVED CENTRE	Acute Mental Health Admission Unit, Kerry General Hospital
NUMBER OF WARDS	2
NAMES OF UNITS OR WARDS INSPECTED	Reask Valentia
TOTAL NUMBER OF BEDS	44
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	23 June 2010

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

INTRODUCTION

In 2010, the Inspectorate paid particular attention to Articles 15 to 22 and 26 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 and all areas of non-compliance with the Regulations in 2009 and any other Article where applicable. The Inspectorate was keen to highlight improvements and initiatives carried out in the past year and track progress on the implementation of recommendations made in 2009. Information was gathered from self-assessments, service user interviews, staff interviews and photographic evidence collected on the day of the inspection.

DESCRIPTION

The Acute Mental Health Admission Unit was located within Kerry General Hospital and comprised two wards situated on the ground floor. The entrance door to the approved centre was locked. Residents had access to a beautifully designed and well kept enclosed garden, which featured Japanese style planting, fountains, seating and bird feeders. The garden had been developed on the initiative of mental health staff and supported by local fundraising. The day room cum dining room was open and airy and provided some recreational activities. Valentia unit had recently acquired gym equipment. The approved centre did not have a co-ordinated and planned therapeutic programme.

The accommodation did not provide residents with privacy in vital areas such as toileting and sleeping and a re-think on the deployment of available space was required to address the dignity and privacy needs of all residents. The nursing stations were open and situated on the corridor, and comprised waist high screening running along the desktop. Clinical files were kept in unlocked trolleys and discussions and telephone conversations could be overheard. This inconvenienced and burdened staff and residents alike.

On the day of inspection there were 38 residents. One resident was on leave, and six residents were involuntarily detained. There was one child resident. Many of the senior clinical posts were filled on acting-up basis. The approved centre had plans to develop a four-bed high observation unit, and awaited funding approval.

DETAILS OF WARDS IN THE APPROVED CENTRE

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Reask	25	21	General Adult Teams
Valentia	19	17	General Adult Teams

QUALITY INITIATIVES

- The approved centre had introduced a structured method for staff allocation to ensure continuity of staff and care on each unit.
- Clinical staff met weekly on a Friday to review bed management.

- A clinical governance committee had been established.
- A policy committee had been set up and met monthly.
- Two nursing staff were trained and registered to prescribe medication and a policy was in place.
- Three nursing staff had been trained as trainers in CPR (Cardio-Pulmonary Resuscitation). Three nursing staff were trained in PMAV (Prevention and Management of Aggression and Violence).
- Nursing staff had taken part in suicide prevention training, entitled "STORM", a skills on risk assessment and management programme, and "Safetalk" a programme on engaging in dialogue and awareness training. Nursing staff had also undertaken training in the suicide prevention programme entitled "ASSIST".
- The nursing care plan had been developed to support the practice of the Rules on Seclusion.

PROGRESS ON RECOMMENDATIONS IN THE 2009 APPROVED CENTRE REPORT

1. The practice of transferring to St. Finan's should cease. This required urgent progression of the plans for the four-bedded high observation unit at Kerry General Hospital.

Outcome: Three residents had been transferred to St. Finan's for therapeutic reasons. There was no secured funding and no date set for the development of the four-bedded high observation unit.

2. Acting posts should be filled on a permanent basis.

Outcome: The Employment Control Framework had impacted significantly and meant that posts, including senior clinical posts, which fell vacant, were only filled in an acting capacity. Management indicated that there had been problems in securing acting up allowances for staff and this impacted on morale.

3. Individual care plans must be implemented in accordance with the definition in the Regulations.

Outcome: The approved centre did not have individual care plans as required in the Regulations.

4. A range of therapeutic services and programmes and activities must be provided.

Outcome: This had not been addressed. The approved centre stated that it did not know what therapeutic services and programmes it might provide from one week to the next. There was no evident co-ordination or planning of therapeutic services and programmes.

5. A policy on transfer of residents to and from the approved centre must be implemented.

Outcome: A policy had been developed on the transfer of residents.

6. A system of ensuring privacy for residents using toilets and bathing areas must be implemented.

Outcome: Privacy locks had been fitted to some shower rooms and a lavatory. Most lavatories remained without locks. Lavatories opened directly onto the main corridor and did not make any provision for privacy.

7. The problem in the shower area where water was spilling onto the floor must be remedied.

Outcome: The relevant shower had been refurbished.

8. General policies relating to ordering, storing and administration of medications must be implemented.

Outcome: A policy had been developed in accordance with Article 23 of the Regulations.

9. The service was very poorly resourced, with numbers of health and social care professionals being limited; the teams should be fully staffed to provide sufficient skills to meet the needs of the residents.

Outcome: The number and mix of health and social care health professionals was insufficient.

10. The risk management policy must be reviewed in line with the Code of Practice on Notification of Deaths and Incident Reporting.

Outcome: A governance committee had been set up and reviewed all incidents as a part of its remit. The risk policy did not comply with all the requirements of Article 32 of the Regulations.

11. The policy on Seclusion must be reviewed annually.

Outcome: The Seclusion policy had been reviewed on the 19 August 2009.

12. The policy on Physical Restraint must be reviewed annually.

Outcome: The policy provided was not signed or updated.

13. The approved centre should provide age-appropriate facilities, programmes of activity and advocacy for children. Staff should be trained in the care of children.

Outcome: The approved centre was unsuited to the admission of children and all the above issues were unresolved.

PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE, AND SECTION 60, MHA 2001

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

Article 4: Identification of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 5: Food and Nutrition

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 6 (1-2): Food Safety

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*	X	

Justification for this rating:

A new kitchenette had been installed in December 2009. The environmental health officer's report was available for inspection. A menu was displayed with a choice between a hot main-course or a salad was available for residents. The dining room was bright and spacious and a number of residents expressed satisfaction with the quality of the meals.

Article 7: Clothing

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 8: Residents' Personal Property and Possessions

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 9: Recreational Activities

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 10: Religion

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 11 (1-6): Visits

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 12 (1-4): Communication

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 13: Searches

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 14 (1-5): Care of the Dying

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 15: Individual Care Plan

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*	X	
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		X

Justification for this rating:

The Inspectorate examined a number of individual case files in Reask and Valentia wards. None of the case files examined contained individual care plans as required by the Regulations.

Multidisciplinary progress notes did not, in general, identify the discipline of the signatory. Nursing staff were not able to identify who had signed several of the multidisciplinary case reviews, nor who had signed progress notes. The nursing care plans and progress notes were consistent and often indicated that the resident had been consulted and signed their own nursing plan. Nursing staff completed a “pre-ward round review” sheet and informed the Inspectorate that this informed the development of a multidisciplinary team (MDT) care plan, however, all appeared to be signed by nursing personnel only and thus did not constitute MDT care plans.

Breach: 15

Article 16: Therapeutic Services and Programmes

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*	X	
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		X

Justification for this rating:

The approved centre stated that it was not able to identify what therapeutic services and programmes might be provided from one week to the next. As a result, individual care planning and reviews did not specify and record therapeutic goals and interventions. The occupational therapy (OT) staff delivered two sessions each week. Based on the individual case files reviewed, it was not evident if these OT interventions were targeted to meet individual assessed needs or more general in scope.

The noticeboard listed a number of timetabled activities, including exercise, relaxation, a newspaper group and a walking group. These activities were provided on an ad-hoc basis by nursing staff as demands allowed. Activities were not linked to individual care plans. There were no activities taking place at the time of the inspection.

There was evidently a very active chaplaincy service as case files included regular and detailed signed reports and updates.

Breach: 16 (1) (2)

Article 17: Children's Education

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

One child was resident at the time of inspection. As the school term was over, there was no necessity to provide educational facilities. It was reported that provision for education would be made for children resident longer than two weeks.

Article 18: Transfer of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*	X	

Justification for this rating:

Three residents had been transferred to St. Finan's for therapeutic reasons. The approved centre had a policy of transfers.

Article 19 (1-2): General Health

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

On the day of inspection, one individual had been resident in the approved centre for more than six months. The individual clinical file was reviewed and there was no up-to-date record of a review of general health. The staff indicated that there was no flagging system in operation to alert staff to upcoming review dates.

Breach: 19 (1)

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

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

A comprehensive range of information on both diagnoses and general mental well-being was displayed outside the residents' dining room. The format was accessible and user-friendly and staff printed off leaflets as requested by residents.

The notice board in the day room listed the members and contacts for of the multidisciplinary teams for each area.

Article 21: Privacy

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*	X	
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		X

Justification for this rating:

The approved centre did not place a premium on privacy and dignity.

The fitting of privacy locks to lavatory doors had ceased some five months previously and many remained without locks. Lavatories opened directly onto the main corridor and in some instances were directly overlooking the nursing desk. This afforded residents little or no privacy.

One female resident had been sleeping for some time on a hospital bed that had been pushed into a dormitory ward. The bed had no surround curtains, no locker or convenient place to store clothes and belongings. The foot of the bed faced directly onto the main corridor, and the bed was situated alongside and overlooked by the window of the nursing station.

The approved centre had a beautiful garden that had been developed on the initiative of staff. The garden was directly overlooked by the floors of the general hospital above. Frosted window panels on the lower panes would have ensured privacy whilst in the garden.

Many of the bedroom dormitories overlooked the car park. Frosted window panels on the lower panes would have afforded privacy to residents.

Breach: 21

Article 22: Premises

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*	X	X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

The shower identified in 2009 as being hazardous owing to water overflowing and causing the floor to be slippy had been refurbished and was satisfactory.

The bathrooms and showers generally required upgrading. The windows were bolted shut and ventilation was poor. The tap handles provided potential ligature points. The shower in Reask was hazardous owing to broken tiles and crumbling plaster.

A very loud hand-dryer in one of the lavatories in Valentia was of such volume as to disrupt sleep in the adjacent dormitory.

The ceiling tiles in the ECT recovery room required replacement and there was a general sense of clutter as this room was used for multiple purposes.

The approved centre staff stated that there was generally a protracted delay in getting work done by the maintenance department.

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*	X	
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

The approved centre had a policy on the ordering, prescribing, storing and administration of medication.

Article 24 (1-2): Health and Safety

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 25: Use of Closed Circuit Television (CCTV)

CCTV was not used in the approved centre.

Article 26: Staffing

WARD OR UNIT	STAFF TYPE	DAY	NIGHT
Reask	Nursing Included 1 CNM2, and 2 specials	6	3
Valentia	Nursing, included 1 CNM2	4	2

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*	X	X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

Multidisciplinary teams visited the approved centre and provided input on an individual and sessional basis. Clinical psychology provided input as needed, and occupational therapy and social work provided fixed sessions and responded to individual referrals. None of the sector teams had a full complement of staff.

Breach: 26

Article 27: Maintenance of Records

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*	X	
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		X
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

The Inspectorate found that it was not easy to retrieve relevant documentation from the individual clinical files. In some files examined, the envelope pockets at the back of the file were torn and important information was spilling out. Nursing staff endeavoured to assist in retrieving information and in identifying who had signed various entries in the clinical files and encountered difficulty also.

Breach: 27.1

Article 28: Register of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 29: Operating policies and procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

The policy on discharge was out of date, having been due for review in 2009. The risk policy did not meet the requirements of the Regulations.

Breach: 29

Article 30: Mental Health Tribunals

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 31: Complaint Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		X
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*	X	

Justification for this rating:

The approved centre had a policy on complaints and a notice advising residents was displayed, however, there was no nominated person in the approved centre to deal with complaints. Complaints were sent to the area administrator.

Breach: 31 (4)

Article 32: Risk Management Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*	X	X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

The approved centre had recently set up a governance committee and part of its brief was to review incidents. The risk management policy did not comply with all the requirements of Article 32 of the Regulations.

Breach: 32

Article 33: Insurance

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 34: Certificate of Registration

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

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

SECLUSION

Use: There were two rooms in the approved centre which were used either as bedrooms or seclusion rooms. The physical structure and furnishings of the rooms were not suitable to ensure resident safety if being used for seclusion. The service had used seclusion on one occasion in 2010 up to the date of the inspection. The seclusion registers in Reask and Valentia were examined and were satisfactory.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
3	Orders	X			
4	Patient dignity and safety	X			
5	Monitoring of the patient	X			
6	Renewal of seclusion orders	X			
7	Ending seclusion	X			
8	Facilities				X
9	Recording	X			
10	Clinical governance			X	
11	Staff training			X	
12	CCTV	NOT APPLICABLE			
13	Child patients	NOT APPLICABLE			

Justification for this rating:

The seclusion register was examined and found to be in order. The seclusion facility was not appropriate to resident safety and the seclusion facilities were used as bedrooms. Staff reported that they had not received training in the management of seclusion and the approved centre did not provide a log of staff training. Three nursing staff had received training in the therapeutic management of aggression and violence. The nursing care plans had been developed to include the Rules Governing the Use of Seclusion.

Breach: 8.3, 8.4, 10.2(b), 11.2

ECT (DETAINED PATIENTS)

Use: No detained patient was receiving ECT at the time of inspection.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
2	Consent	NOT APPLICABLE			
3	Information	X			
4	Absence of consent	NOT APPLICABLE			
5	Prescription of ECT	NOT APPLICABLE			
6	Patient assessment	NOT APPLICABLE			
7	Anaesthesia	NOT APPLICABLE			
8	Administration of ECT	NOT APPLICABLE			
9	ECT Suite			X	
10	Materials and equipment	X			
11	Staffing		X		
12	Documentation	NOT APPLICABLE			
13	ECT during pregnancy	NOT APPLICABLE			

Justification for this rating:

The ECT facilities comprised a treatment room and recovery room. The recovery room was multifunctional and on the day of inspection, was being used as the tribunal room. The ECT suite did not have a private waiting area. The designated nurse for ECT had not had training in ECT. There was a designated consultant psychiatrist for ECT.

Breach: 9.2, 11.7.

MECHANICAL RESTRAINT

Use: Mechanical restraint was not used by the approved centre.

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

PHYSICAL RESTRAINT

Use: The Clinical Practice Form book on Physical Restraint on Reask and Valentia wards were examined.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
5	Orders		X		
6	Resident dignity and safety	X			
7	Ending physical restraint	X			
8	Recording use of physical restraint	X			
9	Clinical governance	X			
10	Staff training	X			
11	Child residents	NOT APPLICABLE			

Justification for this rating:

There had been three incidents involving two residents on Reask and all documentation had been satisfactorily completed in relation to those incidents. Two of the Clinical Practice Forms in Valentia ward were incomplete.

All staff had undergone training in Crisis Prevention Intervention (CPI) and staff were being trained in the prevention and management of aggression and violence (PMVA). The service had an up-to-date signed policy on restraint.

Breach: 5.7 (b)

ADMISSION OF CHILDREN

Description: There was one voluntary child resident on the day of inspection. The resident was nursed in a single room and on a one to one basis. The relevant consent forms had been completed.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
2	Admission				X
3	Treatment	X			
4	Leave provisions	X			

Justification for this rating:

The approved centre was unsuitable for the admission of children.

Breach: 2.5 (b) (e) (g)

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

Description: Two individuals had died in 2010 and their deaths had been notified to the Mental Health Commission. Incident forms were completed after any incident in the wards, and these were forwarded to administration, where a record on the Health Service Executive STARS web system was maintained. Nursing staff did not have an overview of incidents within their units because no copies of the incident forms were kept on the wards.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
2	**Notification of deaths**	**X**			
3	**Incident reporting**	**X**			
4	**Clinical governance**		**X**		

Justification for this rating:

The risk management policy did not comply with all the requirements of Article 32 of the Regulations.

Breach: 4.1

ECT FOR VOLUNTARY PATIENTS

Use: No resident was receiving ECT at the time of inspection.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
4	Consent	NOT APPLICABLE			
5	Information	X			
6	Prescription of ECT	NOT APPLICABLE			
7	Assessment of voluntary patient	NOT APPLICABLE			
8	Anaesthesia	NOT APPLICABLE			
9	Administration of ECT	NOT APPLICABLE			
10	ECT Suite			X	
11	Materials and equipment	X			
12	Staffing		X		
13	Documentation	NOT APPLICABLE			
14	ECT during pregnancy	NOT APPLICABLE			

Justification for this rating:

The ECT suite did not have a private waiting area. The designated nurse had not received ECT training. There was a designated consultant psychiatrist.

Breach: 10.2, 12.6

ADMISSION, TRANSFER AND DISCHARGE

Description: Residents were admitted, transfered and discharged from the approved centre. The clinical files of some of the residents were examined.

Part 2 Enabling Good Practice through Effective Governance

The following aspects were considered: 4. policies and protocols, 5.privacy confidentiality and consent, 6. staff roles and responsibility, 7.risk management, 8. information transfer, 9. staff information and training.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
	X		

Justification for this rating:

The admission policy was out of date.

The risk policy did not comply with all the requirements under Article 32 of the Regulations. The stated review date for the policy on risk was the 16 August 2007 and there was no indication whether the review had taken place or not. The policy did not address all the aspects outlined in the Regulations.

Breach: 4.1, 7.1, 9.3

Part 3 Admission Process

The following aspects were considered: 10. pre-admission process, 11. unplanned referral to an Approved Centre, 12. admission criteria, 13. decision to admit, 14. decision not to admit, 15. assessment following admission, 16. rights and information,17. individual care and treatment plan, 18. resident and family/carer/advocate involvement, 19. multidisciplinary team involvement, 20. key-worker, 21. collaboration with primary health care community mental health services, relevant outside agencies and information transfer, 22. record-keeping and documentation, 23. day of admission, 24. specific groups.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
	X		

Justification for this rating:

Residents did not have individual care plans as specified in the Regulations. There was no evidence of key-working.

Breach: 17.1, 20

Part 4 Transfer Process

The following aspects were considered: 25. Transfer criteria, 26. decision to transfer, 27. assessment before transfer, 28. resident involvement, 29. multi-disciplinary team involvement, 30. communication between Approved Centre and receiving facility and information transfer, 31. record-keeping and documentation, 32. day of transfer.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
X			

Justification for this rating:

The approved centre had a policy on the transfer of a resident to and from an approved centre. The individual clinical files examined demonstrated that the practice was in accordance with the Code of Practice.

Part 5 Discharge Process

The following aspects were considered: 33. Decision to discharge, 34. discharge planning, 35. pre-discharge assessment, 36. multi-disciplinary team involvement, 37. key-worker, 38. collaboration with primary health care, community mental health services, relevant outside agencies and information transfer, 39. resident and family/carer/advocate involvement and information provision, 40. notice of discharge, 41. follow-up and aftercare, 42. record-keeping and documentation, 43. day of discharge, 44. specific groups.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
	X		

Justification for this rating:

The approved centre's policy on discharge was up-to-date. The policy described protocols in respect of discharge of homeless and elderly residents. The service did not operate a key-worker system.

Breach: 37.1

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

Description: ***The following aspects were considered: 5. policies, 6. education and training, 7. inter-agency collaboration, 8. individual care and treatment plan, 9.communication issues, 10. environmental considerations, 11. considering the use of restrictive practices, 12. main recommendations, 13. assessing capacity***

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
			X

Justification for this rating:

Staff had not received training in working with individuals with an intellectual disability and mental illness. The approved centre had not developed the relevant policy. Residents did not have individual care plans as specified in the Regulations.

Breach: 5, 6, 8

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

SECTION 60 – ADMINISTRATION OF MEDICINE

Description: One resident was detained for a period longer than three months and Form 17 had been completed.

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

Justification for this rating:

Form 17 had been completed.

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

Description: No child had been admitted under Section 25 up to the date of the inspection.

SECTION THREE: OTHER ASPECTS OF THE APPROVED CENTRE

SERVICE USER INTERVIEWS

One resident spoke with the Inspectorate concerning their admission and was advised about discussing their concerns with their treating team and other agencies.

MEDICATION

The medication sheets were in booklet format. They were quite clear. However in a number of cases stop dates and signatures were not inserted for discontinuation of medication. PRN (as required) medication was separate from regular medication. Indications for PRN medications were not given. Forty eight per cent were prescribed more than one antipsychotic medication.

MEDICATION ACUTE

NUMBER OF PRESCRIPTIONS:	42
Number on benzodiazepines	16 (38%)
Number on more than one benzodiazepine	3 (7%)
Number on regular benzodiazepines	14 (33%)
Number on PRN benzodiazepines	4 (10%)
Number on hypnotics	7(17%)
Number on Non benzodiazepine hypnotics	4 (10%)
Number on antipsychotic medication	34 (81%)
Number on high dose antipsychotic medication	11 (26%)
Number on more than one antipsychotic medication	20 (48%)

Number on PRN antipsychotic medication	**2 (5%)**
Number on antidepressant medication	**13 (31%)**
Number on more than one antidepressant	**5 (12%)**
Number on antiepileptic medication	**9 (21%)**
Number on Lithium	**6 (14%)**

OVERALL CONCLUSIONS

The approved centre was located within the general hospital and with an attractive outlook over gardens and open space. A particular feature of the approved centre was the open and airy day room cum dining room and the enclosed garden. Interactions between staff and residents impressed as being relaxed and easy in manner. Many of the residents were re-admissions and were known to staff. Several residents commented positively to the Inspectorate about their nursing care.

The approved centre did not attach any premium to dignity and respect. The lack of privacy afforded residents whilst toileting and in one instance whilst sleeping in bed, was shocking. Dignity was a basic human right and should be especially respected in a healthcare setting. Seclusion rooms continued to be used as bedrooms which were contrary to the Rules on Seclusion.

Despite best intentions, the service had not made progress with the provision of individual care plans (ICP's) for residents. Indeed, the majority of fundamental issues highlighted as problematic in the Inspectorate Report of 2009 had not been addressed. There was an apparent sense of enervation in staff. Several key staff were in acting-up roles. The recent arrival of an acting Director of Nursing was to be welcomed and should bolster leadership. The clinical director post was a recent appointment also. There were a broad range of priority issues to be addressed by senior management.

RECOMMENDATIONS 2010

1. Individual care plans must be implemented in accordance with the definition in the Regulations.

2. The approved centre should, as a matter of urgency, ensure the privacy of all residents whilst sleeping and toileting.

3. The seclusion room was unsafe and its use should be reviewed by clinical management. In addition, seclusion rooms should not be used as bedrooms.

4. The policy committee in the approved centre should review, edit and rationalise all existing policies so as to ensure cohesion, full compliance and eliminate duplication.

5. The outstanding policy on the Admission of Children should be updated.

6. The approved centre should amend its risk policy in order to comply with the Regulations.

7. The senior management team should commission a multidisciplinary group to review and plan for the delivery of appropriate and evidence based therapeutic services and programmes. Therapeutic services and programmes should be linked to individual care plans.