Report of the Inspector of Mental Health Services 2008

HSE AREA	HSE South
CATCHMENT	Kerry
MENTAL HEALTH SERVICE	Kerry
APPROVED CENTRE	Acute Mental Health Admission Unit, Kerry General Hospital
NUMBER OF UNITS OR WARDS	2
UNITS OR WARDS INSPECTED	Valencia Reask
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	50
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	12 June 2008

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

INTRODUCTION

In 2008, there was a focus on continuous quality improvement across the Mental Health Service. 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 2007. Information was gathered from service user questionnaires, staff interviews and photographic evidence collected on the day of the inspection. The Inspectorate met with the hospital manger, clinical director, director of nursing, an assistant director of nursing, CNM3 and CNM 2 on the wards, representatives of clinical psychology, occupational therapy and social work. The Inspectorate facilitated a feedback meeting after the inspection.

DESCRIPTION

The Acute Mental Health Admission Unit was located in Kerry General Hospital. It had two wards, Valencia and Reask. Each ward had 25 beds. Many of the nursing staff on the unit were in acting posts and this had been the case for a number of years.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Valencia	25	24	General adult teams
Reask	25	24	General adult teams

It was evident to the Inspectorate from talking to various members of staff that all disciplines were routinely involved in decision-making and development issues in the service. In stark contrast to this was the lack of multidisciplinary team working at clinical team level in the unit, apart from one sector team and the rehabilitation team. At the time of the inspection, most of the health and social care professionals were shared across general adult teams and specialty teams, creating some constraints in accessibility and in the ability to focus solely on development of speciality skills. As the service develops, it will need to ensure that the numbers and skills mix of staff continue to be appropriate to the needs of the residents as outlined in Article 26 (2).

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. The unit should commence using individual care plans.

Outcome: Only one of the sector teams and the rehabilitation team had commenced using multidisciplinary care plans.

2. Existing plans for the 4-bed high observation unit should be reviewed with clinical staff to ensure that the most modern and clinically sound design is used.

Outcome: Clinical staff had been afforded opportunities to be involved in the planning of the new unit. The plans had been sent to the Local Health Manager for funding approval.

3. The layout of the seclusion rooms should be addressed.

Outcome: Each ward had one seclusion room. The layout remained unchanged from last year's inspection. Staff reported that funding had been approved for the renovation and upgrade of the facilities. It was expected that work would be commence in July 2008 and be completed within two to three weeks.

MDT CARE PLANS 2008

Only one of the multidisciplinary teams had started to use individual care plans as defined in the Regulations. Of concern to the Inspectorate was the lack of progress and leadership across the other teams in implementing multidisciplinary team working.

GOOD PRACTICE DEVELOPMENTS 2008

- Introduction of multidisciplinary care plans on one sector team and the rehabilitation team.
- Emphasis on nursing staff working individually with residents, with nurses having protected time to implement this.
- Community meetings were held every weekend between the residents and nursing and medical staff.
- Staff fund-raising had facilitated the design and opening of a sensory garden.
- Best practice guidelines for admissions had been implemented.
- Information leaflets for residents on a range of topics were distributed in the approved centre.

SERVICE USER INTERVIEWS

A number of residents asked to meet with the Inspectorate. One resident had concerns specifically in relation to an impending mental health tribunal and these concerns were passed on to the nurse in charge of the unit. Generally, residents felt involved with the care provided by medical and nursing staff. They all knew their consultant psychiatrist and felt the majority of nurses were approachable and helpful.

Residents reported limited access to health and social care professionals. They found that most of the activities were helpful but sometimes too much information was given in a short space of time, and this was hard to take in. None had concerns about their physical health, all of them reporting that they had regular physicals and that blood was taken as required.

The provision of information on medication was an issue. They reported that they had to ask for information after they were prescribed the medication, instead of being informed prior to prescription. They felt the medical staff only advised them verbally of changes in their medication. More written information was requested.

There were some issues regarding lack of privacy. None of the showers could be locked and there was no privacy when using the pay phone.

2008 AREAS FOR DEVELOPMENT ON THE QUALITY, CARE AND TREATMENT MENTAL HEALTH ACT 2001 SECTION 51 (b)(i)

1. Each resident must have an individual care plan as defined in the Regulations [Article 15].

2. Funding should be made available to ensure that each team has a core complement of dedicated health and social care professionals to enhance the quality of care and treatment for residents and to ensure an adequate number and appropriate skills mix of staff [Article 26].

3. Documentation regarding consent for admission and treatment of children could be enhanced by the introduction of a parental consent form (and also a young person's consent form, if appropriate).

4. Documentation regarding physical restraint could be enhanced by devising a checklist in accordance with the code of practice.

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

6. Funding should be made available, on a priority basis, for the 4-bed high observation unit.

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

INTRODUCTION

In 2008, the inspection focused on areas of non-compliance identified in 2007. In addition, the Inspectorate re-inspected compliance with all the articles in part three of the Regulations (15–21 and 26) and the Rules and the Codes of Practice in each approved centre. In 2008, two new codes of practice were issued and compliance with them was inspected. Where conditions were attached, they were inspected in detail. Evidence of compliance was established through three strands:

- Inspection of compliance where there was a breach in 2007. This was cross-referenced with the action plan submitted to the MHC Standards and Quality Assurance Division.
- Written evidence requested prior to the inspection, for example policies.
- Evidence gathered during the course of the inspection from staff, service users, photographic evidence and photocopies.

2.1 EVIDENCE OF COMPLIANCE WITH CONDITIONS ATTACHED TO REGISTRATION

As no conditions were attached, this was not applicable.

2.2 EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d) ON 12 JUNE 2008

Article 6 (1-2) Food Safety

Reports from the Environmental Health Officer were reviewed by the Inspectorate along with minutes of meetings in the hospital where outstanding issues had been discussed, progressed and resolved.

Compliant: Yes

Article 7: Clothing

On the day of the inspection, a number of residents were wearing night clothes. This was documented in their clinical file as either the resident's preference or as part of their care plan. Residents who were prescribed night clothes at admission had this decision reviewed within 48 hours.

Compliant: Yes

Article 11 (1-6): Visits

The unit had policies and procedures for visits.

Compliant: Yes

Article 12 (1-4): Communication

The unit had a policy in place on communication.

Compliant: Yes

Article 13: Searches

The operational policy in relation to finding illicit substances was submitted to the Inspectorate later.

Compliant: Yes

Article 15: Individual Care Plan

Only one of the three sector teams was implementing multidisciplinary care planning on the ward. For residents under the care of the other sector teams, nursing staff on the ward were completing the care plan forms but other members of the teams were not participating in the process in a formal or structured way.

Following the inspection, the service reported that all teams had been reminded to complete the multidisciplinary care plans and this would be audited over the coming months.

Breach: Not all of the residents had an individual care plan [Article 15] as defined in the Regulations [Article 3].

Compliant: No

Article 16: Therapeutic Services and Programmes

A range of individual and group therapeutic services and programmes was provided for residents by clinical nurse specialists, occupational therapists, social workers and psychologists. However, these were not in accordance with the individual's care plan.

Following inspection, the service reported that this issue was being addressed through a pilot project in one of the sectors and would be reviewed as part of the care plan audit in November 2008.

Breach: Therapeutic activities and services must be linked to each resident's individual care plan which was absent for most of the residents [Article 16 (1)].

Compliant: No

Article 17: Children's Education

There had been four admissions of children in the first five months of 2008, all were voluntary. Arrangements had been made to liaise with the young person's school if needed.

Compliant: Yes

Article 18: Transfer of Residents

Residents were still on occasion transferred to St Finan's Hospital in Killarney if their needs could not be met in the acute unit. It was reported that the main reason for this was the challenging behaviour presented. The creation of a high observation unit would ensure that residents no longer needed to be transferred.

Compliant: Yes

Article 19 (1-2): General Health

There was good access to medical specialties in the general hospital. Physical examinations were carried out at admission and every six months and there was evidence of these in the clinical files reviewed.

Compliant: Yes

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

An information booklet was provided for residents containing details about the wards and various housekeeping arrangements. This was confirmed by residents. A member of the Irish Advocacy Network (IAN) visited the unit each Tuesday.

Residents interviewed said that information on diagnosis and medications was available through their primary nurse or consultant psychiatrist, but was not routinely given, and no written information had been given to any of them about their diagnosis. There was a policy in place.

Following inspection, the service reported that residents would be provided with information about their sector teams, fact sheets on diagnoses and information on medication would be provided.

Breach: Details of the resident's multidisciplinary team were not provided to the resident [Article 20 (1)(a)], written information about diagnosis was not routinely given to residents. [Article 20 (1)(c)], and information on the indications for and possible side effects of medications were not routinely given to residents [Article 20 (1)(e)].

Compliant: No

Article 21: Privacy

Breach: The service was compliant.

Compliant: Yes

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

The service was compliant and a policy was now in place.

Compliant: Yes

Article 24 (1-2): Health and Safety

The service was compliant a policy was now in place.

Compliant: Yes

Article 25: Use of Closed Circuit Television (CCTV)

CCTV was not used for the purpose of observing residents.

Compliant: Yes

Article 26: Staffing

Five general adult teams had access to the unit. There were 11 registered nurses on duty each day including a CNM2. There were six registered nurses on night duty. Nursing staff reported that they often worked under the agreed complement of staff due to staff shortages. On occasions when special one-to-one nursing was required, this came out of the existing complement, stretching the existing complement of nursing staff on the unit. Three sessions of occupational therapy were available on the ward and staff reported that this was not enough given the needs of the residents. The service reported that while it tried to ensure ongoing multidisciplinary input to the approved centre, there were resource issues impacting on this.

Breach: The numbers and skill mix of staff on the unit was not appropriate to the assessed needs of the residents [Article 26 (2)].

Compliant: No

Article 27: Maintenance of Records

The service was compliant and a policy was in place.

Compliant: Yes

Article 29: Operating policies and procedures

A system was in place to review all policies.

Compliant: Yes

Article 31: Complaint Procedures

Local complaints were discussed at the weekly community meetings between staff and residents. The complaints procedure was displayed on the unit. A record of complaints was submitted to the Inspectorate. There was a policy in place.

Compliant: Yes

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

SECLUSION

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Rules for the Use of Seclusion.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Orders**	The orders for seclusion were clear. It was noticeable that a significant number of seclusion episodes were to prevent the resident from absconding from the unit.
3	**Patients' dignity and safety**	Dignity and safety was maintained in difficult circumstances as the rooms were also used as bedrooms. One of the two seclusion rooms was out of use due to damage caused to the room some months previous.
4	**Monitoring of the patient**	There was comprehensive monitoring of the resident in seclusion.
5	**Renewal of seclusion orders**	The renewal orders were complete.
6	**Ending seclusion**	Clearly documented.
7	**Facilities**	Two high-observation rooms on each ward used for seclusion were located near the nurses' stations and on the main corridor. The problems identified in the physical layout of the rooms in 2005 remain: there was poor ventilation, a hard finish on the walls, no communication facility, and toilet facilities were located away from the rooms.
8	**Recording**	Detailed and comprehensive.
9	**Clinical governance**	There was a policy in place and the service had completed an annual report on the use of seclusion.
10	**Staff training**	Staff were not receiving regular training in physical restraint techniques which has an impact on seclusion.
11	**CCTV**	Not applicable
12	**Child patients**	Not applicable

Breach: Two bedrooms were also used for seclusion [Section 7.5] . Staff were not receiving regular training in restraint [Section 10.1] and [Section 10.2] and therefore the record of staff training could not be up to date.

Compliant: No

ECT

The ECT register, clinical files and the ECT suite were reviewed. The clinical documentation was excellent. There has been a low use of ECT over the last two years with no one being prescribed ECT since February 2008.

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Rules for the Use of ECT.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Consent**	Compliant
3	**Information**	Compliant
4	**Absence of consent**	Compliant
5	**Prescription of ECT**	Compliant
6	**Patient assessment**	Compliant
7	**Anaesthesia**	Compliant
8	**Administration of ECT**	Compliant
9	**ECT Suite**	Compliant
10	**Materials and equipment**	Compliant
11	**Staffing**	Compliant
12	**Documentation**	Compliant
13	**ECT during pregnancy**	Not applicable

Compliant: Yes

MECHANICAL RESTRAINT

Staff reported that mechanical restraint was not used on the unit. The approved centre submitted a policy on mechanical means of bodily restraint after the inspection.

Compliant: Yes

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

PHYSICAL RESTRAINT

Staff were not receiving ongoing training or re-fresher courses in restraint techniques.

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Code of Practice for the Use of Physical Restraint.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Orders**	Compliant
3	**Resident dignity and safety**	Compliant
4	**Ending physical restraint**	Compliant
5	**Recording use of physical restraint**	Compliant
6	**Clinical governance**	Compliant
7	**Staff training**	Non-compliant
8	**Child residents**	Not applicable

Breach: Staff were not receiving ongoing training or refresher courses in restraint techniques [Section 7.1] and as a consequence the record of staff training in restraint was not up to date [Section 7.2] .

Compliant: No

ADMISSION OF CHILDREN

Four children had been admitted on a voluntary basis for the first five months of 2008. In one of the clinical files it was difficult to find a record of parental consent to admission and treatment. The file showed regular and detailed involvement from the local child and adolescent team in the care and treatment of the young person.

The community mental health nurse from the child and adolescent team visited the unit regularly and provided guidance with regard to age appropriate care. Generally children under 14 years of age were admitted to the paediatric wards and the acute mental health unit tried to take only children over 16 years. This left a gap in the in-patient services for children aged 14–16 years.

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Code of Practice for the Admission of Children under the MHA 2001.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Admission**	Non-compliant. The approved centre reported that work was under way in relation to individual risk assessment for children, Garda vetting and age appropriate advocacy services and this was planned to be completed by year end.
3	**Treatment**	Compliant
4	**Leave provisions**	Compliant

Breach: Section 2.5 (i), Section 2.5 (g) and Section 2.5 (d)(i).

Compliant: No

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Code of Practice for the Notification of Deaths and Incident Reporting.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Notification of deaths**	Compliant
3	**Incident reporting**	Compliant
4	**Clinical governance**	Compliant

Compliant: Yes

ECT FOR VOLUNTARY PATIENTS

The ECT register, a clinical file and the ECT suite were reviewed during the inspection. There has been low use of ECT over the last two years. The clinical documentation was excellent.

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Code of Practice for the Use of ECT for Voluntary Patients.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Consent**	Compliant
3	**Information**	Compliant
4	**Prescription of ECT**	Compliant
5	**Assessment of voluntary patient**	Compliant
6	**Anaesthesia**	Compliant
7	**Administration of ECT**	Compliant
8	**ECT Suite**	Compliant
9	**Materials and equipment**	Compliant
10	**Staffing**	Compliant
11	**Documentation**	Compliant
12	**ECT during pregnancy**	Not applicable

Compliant: Yes

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

Section 60 was in order. In the files reviewed there was evidence that the patient was consenting to the medication. Section 61 was not applicable.

Compliant: Yes