Draft Report of the Inspector of Mental Health Services 2009

MENTAL HEALTH SERVICE	HSE West
APPROVED CENTRE	Cappahard Lodge
CATCHMENT AREA	Clare
NUMBER OF WARDS	2
NAMES OF UNITS OR WARDS INSPECTED	Male Unit Female Unit
TOTAL NUMBER OF BEDS	35
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	3 June 2009

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

DESCRIPTION

Cappahard Lodge was registered as an approved centre for the purposes of the Mental Health Act 2001 in October 2008. The centre had 35 beds, including four beds which were used for planned respite admissions. The centre was the clinical responsibility of the Clare Mental Health Services for Older People (CMHSOP) psychiatry of later life team.

The unit catered for residents with both organic and functional illnesses. On the day of the inspection there were 30 residents, none of them detained. A number of the residents lacked capacity to make decisions about their care and treatment. The unit was locked for the safety of a number of residents who were at risk of wandering. A number of residents had complex dependency levels and required full nursing care.

Despite the size of the unit, it was divided into male and female wards, with some differing practice and management protocols. This appeared to be in conflict with the unit's philosophy of a person-centred care approach.

It was reported to the Inspectorate that despite the unit being divided into two separate wards, the number of beds was taken as a whole for the unit with no specific number of beds being allocated to each ward.

The HSE had commissioned an independent review of the policies and procedures for Cappahard Lodge. It was published since our last inspection.

DETAILS OF WARDS IN THE APPROVED CENTRE

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Cappahard Lodge	35	30	Psychiatry of later life

QUALITY INITIATIVES

- The service had secured funding to develop a dementia-specific sensory garden to provide a safe outdoor space for residents. The contract was out to tender at the time of the inspection.
- The service had been successful in receiving funding to develop a protocol for palliative care in dementia.
- As part of a practice development programme, a dementia-friendly environment was being incorporated into all elements of environmental change.

PROGRESS ON RECOMMENDATIONS IN THE 2008 APPROVED CENTRE REPORT

This was a newly-registered approved centre. There were no recommendations on registration.

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	2008	2009
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.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

All medication record books had the photo-identification of each resident on the front. The practice was that two registered psychiatric nurses normally administered medication at specific times as indicated on the medication record book. Due to the unit's person centred care approach a resident who was not available at medication times would receive medication from their key worker who would know the resident.

Article 5: Food and Nutrition

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

Drinking water was available. Food was prepared in St. Joseph's Hospital, with all dietary requirements catered for. The day's menu was written on a menu blackboard. The service informed the Inspectorate that more choice could be provided. It was subsequently reported that this was been addressed by the catering department.

Breach: Article 5 (2)

Article 6 (1-2) Food Safety

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

The Environmental Health Officer's report of 14 August 2008 identified that the deep cleaning of the kitchen facilities remain unsatisfactory. The Local Health Manager subsequently reported that remedial steps were taken to ensure compliance. There was no current report from the environmental health officer available on the day of the inspection.

Breach: Article 6 (1)(c)

Article 7: Clothing

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

Residents wore their own labeled clothing. Laundry facilities were present on site.

Article 8: Residents' Personal Property and Possessions

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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	
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

A record of each resident's personal property and possessions was maintained by the service. One copy remained in the book and the other copy was retained in the clinical files. The resident or a family member had access to this information.

Individual resident account folders were maintained in the ward's office. Accounts were signed by two RPNs and receipts for items purchased were maintained within this folder. This procedure was carried out with the resident or a family member who had access to the individual account folders. Residents' pensions payments were administered off-site by the general manager at Teach de Paor.

The service had no written operational policies and procedures relating to residents' personal property and possessions. This was also identified as a breach in July 2008. Subsequently a signed copy was received by the Inspectorate team.

Article 9: Recreational Activities

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

The activation nurse was a 0.5 WTE post but it was reported to the Inspectorate that due to short staffing this was frequently subsumed into the existing staffing complement. There was no consistent programme of recreational activities available to the residents.

It was reported that the snoezelen multisensory room was used frequently on a one-to-one basis. Other activities included hand massage, aromatherapy, activities and outings were also organised. These were dependent on staff availability and interest. Newspapers were provided. Residents had access to television and radio.

Some bedrooms had individual sensory items for residents.

It was subsequently reported that the ADON had been given the task of developing and implementing activities.

Breach: Article 9

Article 10: Religion

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

Residents were facilitated in the practice of their religion as far as was reasonably practicable.

Article 11 (1-6): Visits

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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	
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

There were a number of areas around the unit where visiting could take place. Child visitors had to be accompanied by a responsible adult.

There was no written operational policy and procedure for visits. This was identified as a breach in 2008.

A policy signed by the acting clinical director and the Local Health Manager was submitted to the Inspectorate team following the inspection.

Article 12 (1-4): Communication

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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	
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

It was the custom and practice that the majority of residents who received letters had them opened by staff with their permission or with prior permission of relatives for the purpose of having those letters read to residents. A public phone could be accessed by residents. Incoming calls could also be facilitated to the bed side by the mobile land line phone. No resident had a mobile phone but could obtain one if so wished.

There was a policy in place on the old format. It was dated and for review in 2010.

Article 13: Searches

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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	
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

It was reported to the Inspectorate that searches of residents do not take place. The service had no written operational policies and procedures on searches. This breach was also recorded in 2008.

A policy signed by the acting clinical director and the Local Health Manager was submitted to the Inspectorate team following the inspection.

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

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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	
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

A number of staff received training in palliative care, but written operational policies and protocols for care of residents who were dying were not in place. This had been recorded as a breach also in 2008.

End-of-life discussions with residents and relatives had begun and regular groups of this kind were being planned. Feedback from residents and relatives had been positive.

A policy signed by the acting clinical director and the Local Health Manager was submitted to the Inspectorate team following the inspection.

Article 15: Individual Care Plan

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*	X	X
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

The approved centre did not use individual care plans as defined in the Regulations. There was no evidence of a plan to address this deficit since last year. The nursing staff had begun to use a standardised assessment tool.

Following the inspection, it was reported that care plans would be fully operational by the end of 2009.

Breach: Article 15

Article 16: Therapeutic Services and Programmes

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*	X	X
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

The psychiatry of later life team occupational therapist held a clinic each Friday.

There was an identified need for physiotherapy. Physiotherapy services were not provided at the centre. Any resident who required physiotherapy had access to St. Joseph's Hospital. Staff reported that in some instances this presented practical problems.

A GP was attached to the centre, which was under the clinical responsibility of a consultant psychiatrist, who provided one session per week.

There was no therapeutic programme in place that was linked to a care plan.

Breach: Article 16 (1)

Article 17: Children's Education

Children were not admitted to the approved centre.

Article 18: Transfer of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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	
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

It was reported that no resident had been transferred from the approved centre for treatment to another approved centre. There was no signed written policy and procedure in place at the time of the inspection. This was also a breach in 2008.

A policy signed by the acting clinical director and the Local Health Manager was submitted to the Inspectorate team following the inspection.

Article 19 (1-2): General Health

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

In the clinical files examined, there was no evidence that each resident's general health needs were assessed regularly or that six-monthly physical examinations were carried out. It was unclear who was responsible for completing the examinations. This restricted referral to other health services as required and access to national screening programmes where applicable. All residents were registered with a GP.

The service did not have written operational policies and procedures for responding to medical emergencies at the time of the inspection. A policy signed by the acting clinical director and the Local Health Manager was submitted to the Inspectorate team following the inspection. It had a protocol for responding to medical emergencies.

Breach: Article 19 (1)(a), Article 19 (1)(b), and Article 19 (1)(c).

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

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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	
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

An information booklet provided detailed the team and operational procedures in the centre. There were no details of relevant advocacy and voluntary agencies displayed.

There were no written operational policies and procedures for the provision of information to residents. This had been identified as a breach in 2008.

A policy signed by the acting clinical director and the Local Health Manager was submitted to the Inspectorate team following the inspection. The Local Health Manager also reported that details of advocacy agencies were now displayed.

Article 21: Privacy

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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	
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

One privacy curtain was missing around a bed in a twin room. This had been ordered and it was reported to the Inspectorate that both residents had been offered a single room to facilitate their privacy but had declined the offer as they had become friends and wished to remain in the room together.

Breach: Article 21

Article 22: Premises

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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	
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

The premises were clean but in need of redecoration. There was no plan of maintenance and no records of any such plan retained.

It was subsequently reported that a maintenance plan had been discussed. It was dependent on funding being made available.

Breach: Article 22 (1)(a) and Article 22 (1)(c).

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

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

The practices and procedures for ordering, prescribing, storing and administering medicines were not appropriate, were not suitable and were unsafe.

The approved centre had no written policies relating to the ordering, prescribing and storage of medicines. The approved centre did have a policy on the administration of medication. The procedures and practices in relation to the ordering, prescribing and storing of medicines that were in place made the administration of these medicines unsafe.

The two wards had different processes for administering medications: one ward did not have individualised medications but administered from stock.

A policy signed by the acting clinical director and the Local Health Manager was submitted to the Inspectorate team following the inspection. It was reported that the processes for the administration of medication were being made uniform. No time frame was given.

Breach: Article 23 (1) and Article 23 (2).

Article 24 (1-2): Health and Safety

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

The centre had a health and safety policy in place.

Article 25: Use of Closed Circuit Television (CCTV)

CCTV was not in use at the time of the inspection.

Article 26: Staffing

WARD OR UNIT	STAFF TYPE	DAY	NIGHT
Male Ward	Nurse Household	1 CNM2, 3 Staff 2	2 Staff 0
Female Ward	Nurse Household	1 CNM2, 3 Staff 2	2 Staff 0
Other staff	Consultant psychiatrist or NCHD Occupational therapist GP	1 session a week 1 session a week As required	

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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	
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

It was reported that HSE written policies and procedures relating to the recruitment, selection and vetting of staff applied. Clinical care was provided by nursing staff. A recent audit had highlighted that nurses were spending up to 90 person hours a week completing non-nursing duties. It was reported that the agreed staff complement had not been reached due to staff shortages. It was reported that the activation nurse post was now subsumed into existing staff numbers due to staff shortages.

Health and social care staff were limited to one weekly session of occupational therapy from the psychiatry of later life team. Access to physiotherapy was only available in an external hospital. Medical intervention was provided by a GP on a consult basis and by the consultant psychiatrist in psychiatry of later life, providing one session a week.

A CNM2 was in charge of the centre at all times during the day. At night, the staff nurse in charge had access to the ADON in the acute psychiatric unit at the regional hospital.

Training in moving and handling had been carried out and records maintained. It was reported that training in basic life support had occurred more than three years ago.

Copies of the Act, Regulations, Rules, and Codes of Practices were available for staff on the unit.

Breach: Article 26 (2) and Article 26 (4).

Article 27: Maintenance of Records

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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	
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

Retrieving information from the clinical files examined was not easy. In some instances, clinical information had been written on loose sheets of paper. Photographic evidence was taken.

Written policies and procedures relating to the creation of, access to, retention of and destruction of records were not present.

Documentation in relation to food safety, health and safety and fire inspections were maintained and were examined.

A policy signed by the acting clinical director and the Local Health Manager was submitted to the Inspectorate team following the inspection. It was also reported that the present case file system would be replaced by the end of July 2009.

Breach: Article 27 (1)

Article 28: Register of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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	
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

The register of residents was not compliant with Schedule 1 of the Regulations. This was also recorded as a breach in 2008.

Following the inspection the register spreadsheet file was amended and copy of the updated file was received by the Inspectorate team. The IT system was being updated to include all fields. No time frame for completion was given.

Article 29: Operating Policies and Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

Since the last inspection a new template for writing policies had been introduced. The clinical and corporate governance arrangements in place for this approved centre remained unclear and this lack of clarity was highlighted due to the fact all policies were unsigned. Breaches identified in July 2008 had not been addressed and there was no system in place for writing, reviewing and signing policies.

A policy signed by the acting clinical director and the Local Health Manager was submitted to the Inspectorate team following the inspection. It outlined the procedure for policy development and review.

Article 30: Mental Health Tribunals

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

The approved centre had no facilities for mental health tribunals. It was reported that the facilities in the Department of Psychiatry, Ennis General Hospital, were available. No resident had been detained since the centre was approved.

Article 31: Complaint Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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	
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

The service stated it had received no complaints since it had become an approved centre.

The centre used the HSE policy and procedure relating to making, handling and investigation of complaints. A localised policy remained unsigned. The ADON was the named complaints officer.

A policy signed by the acting clinical director and the Local Health Manager was submitted to the Inspectorate team following the inspection.

Article 32: Risk Management Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

The policy was unsigned. Procedures to address the risk in this Article were not in place. A record of incidents was maintained at the centre. All incidents were reported by the nurse in charge to the ADON with responsibility for the unit who in turn reported to the risk manager for the catchment area. Incidents were placed on the STARS Web tracking system.

Evidence that risks were reviewed and of who reviewed them was not in place. Quarterly returns were not submitted to the MHC. The service had arrangements were in place for the protection of vulnerable adults from abuse.

A policy signed by the acting clinical director and the Local Health Manager was submitted to the Inspectorate team following the inspection.

Breach: Article 32

Article 33: Insurance

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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.*		
Not inspected	*Inspection did not cover this Article.*		

Justification for this rating:

The approved centre's certificate of insurance was inspected.

Article 34: Certificate of Registration

LEVEL OF COMPLIANCE	DESCRIPTION	2008	2009
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.*		
Not inspected	*Inspection did not cover this Article.*	X	

Justification for this rating:

The approved centre's certificate of registration was framed and displayed in a prominent position near the entrance.

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

SECLUSION

Seclusion was not used. A statement to this effect was requested but was not received by the Inspectorate team.

ECT (DETAINED PATIENTS)

ECT was not provided in the approved centre and no residents were receiving ECT in an external hospital on the day of inspection.

MECHANICAL RESTRAINT

Use: Mechanical restraint was used under Part 5 of the Rules. Staff reported that mechanical restraint was not used or initiated. On the day of the inspection, bed rails were in use for one resident. They were not prescribed in the medical file.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
14	Orders	NOT APPLICABLE			
15	Patient dignity and safety	NOT APPLICABLE			
16	Ending mechanical restraint	NOT APPLICABLE			
17	Recording use of mechanical restraint	NOT APPLICABLE			
18	Clinical governance	NOT APPLICABLE			
19	Staff training	NOT APPLICABLE			
20	Child patients	NOT APPLICABLE			
21	Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour				X

Justification for this rating:

There was no prescription in the file for the bed rails inuse. There was no policy in place. This was reported as a breach in 2008.

A policy signed by the acting clinical director and the Local Health Manager was submitted to the Inspectorate team following the inspection. It did not make any reference to Part 5 of the Rules.

Breach: Section 21.1

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

PHYSICAL RESTRAINT

Use: It was reported that it was not used. All staff were trained in Prevention and Management of Violence (PAMV).

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

Justification for this rating:

There was no policy in place on the day of inspection.

A policy signed by the acting clinical director and the Local Health Manager was submitted to the Inspectorate team following the inspection.

ADMISSION OF CHILDREN

Children were not admitted to the approved centre.

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

Description: The service had not reported any incidents since registration.

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:

There was no policy in place that met the requirements of the Code of Practice and Article 32 of the Regulations. Incidents had not been reported to the MHC.

A policy signed by the acting clinical director and the Local Health Manager was submitted to the Inspectorate team following the inspection.

Breach: Section 2 and Section 3.

ECT FOR VOLUNTARY PATIENTS

ECT was not provided in the approved centre and no residents were receiving ECT in an external hospital on the day of inspection.

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

SECTION 60 – ADMINISTRATION OF MEDICINE

As there were no detained patients in the approved centre on the day of inspection, Section 60 did not apply.

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

Section 61 did not apply as no child had been admitted under Section 25.

SECTION THREE: OTHER ASPECTS OF THE APPROVED CENTRE

SERVICE USER INTERVIEWS

No resident asked to speak to the Inspectorate. Residents were greeted by the Inspectorate during the inspection process.

OVERALL CONCLUSIONS

There were a number of dysfunctional systems evident in the approved centre on the day of inspection. There was a lack of managerial and clinical leadership. This resulted in policies not being signed, residents not receiving active and timely reviews and a complete lack of clarity on who was to perform physical examinations. Local systems for management and review of risks were absent. In a single small centre, two separate and complex medication systems were in operation.

A number of residents had no capacity to make informed choices and were dependent on professionals to provide safe and effective care. Scepticism towards the unit being an approved centre was partially responsible for the current level of compliance. Staff must use the protections afforded to residents under the Act to bring about change and improve care.

Following the inspection, outstanding policies and procedures were submitted to the Inspectorate.

In view of the number of breaches on the day of the inspection a copy of this draft report was sent as a matter of priority to the Acting Chief Executive Officer, Mental Health Commission on 8 June 2009. The Mental Health Commission subsequently requested that the Inspectorate undertake an unannounced visit within three months of the date of this inspection.

RECOMMENDATIONS 2009

1. Each resident must have a psychiatric review, nursing assessment and physical examination that was current. A record must be clearly evident in the chart. A system for review must be put in place identifying who was responsible for each review, assessment and examination.

2. All residents who were restrained in accordance with Part 5 of the Rules on mechanical restraint must have this recorded.

3. Documentation must be recorded in accordance with best practice, and according to HSE and professional standards. Each discipline must sign a signature bank and update it at set intervals. Visiting students must also be included.

4. A review of the current system for ordering and prescribing medication must be completed. A single system must be put in place.

5. Each resident must have an individual care plan as defined in the Regulations.

6. The staffing levels and skill mix must be appropriate to the assessed residents needs.

7. The approved centre should operate as a single unit.

8. Physiotherapy services should be provided at the centre where there was an identifiable need.

9. Any programme of redecorating should be carried out with due regard to the specific needs of residents.

10. The centre must have a statement in place that it does practice seclusion and ECT on site.