Report of the Inspector of Mental Health Services 2008

HSE AREA	HSE South
CATCHMENT	North Lee
MENTAL HEALTH SERVICE	North Lee
APPROVED CENTRE	Carraig Mór Centre
NUMBER OF UNITS OR WARDS	2
UNITS OR WARDS INSPECTED	Special Care Continuing Care
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	40
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	19 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 director of nursing, the CNM2s and staff nurses on the units, a CNS in activation, a consultant psychiatrist, and representatives from social work and occupational therapy. A feedback meeting was facilitated following the inspection.

DESCRIPTION

Continuing Care (First Floor): The residents on the first floor were under the care of three different consultant psychiatrists from two different catchments. Since the last inspection, the beds have been reduced by one. There was no advancement on providing a rehabilitation team or appropriate housing for the residents in the community.

Special Care (Ground Floor): This unit was located on the ground floor and was a locked unit under the care of the forensic team. On the day of the inspection, the unit had eight male and ten female residents, nine of them detained. The unit was commended for the detailed and high standard of documentation in relation to the use of seclusion and physical restraint and for the low rates of seclusion.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Special Care	20	18	Forensic
Continuing Care	20	20	General Adult

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. The renovation and building works should commence at the earliest possible date.

Outcome: Building work had commenced.

2. The ground floor should be cleaned to an acceptable standard and audited regularly.

Outcome: The standard of cleanliness had improved substantially and was to a high standard.

3. Policies procedures and protocols must be developed and implemented in accordance with the requirements under the Regulations.

Outcome: The majority of policies were in place. The searches policy needs to be signed off and the risk management policy completed.

4. The forensic team should be adequately staffed to meet the current need and the unmet need in the community.

Outcome: The current staffing resource was not sufficient to meet the demand in the service. The forensic team did not have any psychology input. There were a number of residents in the approved centre with ongoing long-term mental health needs that could be best met by a rehabilitation team working in partnership with the forensic team. The NCHDs from the forensic team provided medical cover for the residents on the first floor.

5. The proposal for a community residence to be built on the grounds for some of the residents and to provide a regional assertive outreach team should be actioned.

Outcome: There was no progress on this recommendation

6. The policy of residents wearing identification wristbands on the ground floor should be reviewed on health and safety grounds and a policy more appropriate to the functioning of the unit should be implemented.

Outcome: Residents no longer wore wrist bands and an alternative was being investigated.

MDT CARE PLANS 2008

Continuing Care: There were no multidisiplinary team care plans on the first floor. The staff expressed frustration at the lack of a rehabilitation team. Three consultant psychiatrists had clinical responsibility for the residents on the ward. They were reviewed regularly but there were no health and social care professionals team members involved. The residents originated from a number of different sectors in the Cork City area.

Special Care: The individual care plan was developed by a multidisciplinary working group from the forensic team. All residents had an up-to-date multidisciplinary team care plan. At admission, each resident had a psychiatric, medical and nursing assessment and an initial care plan was devised. Social work and occupational therapy assessments were completed prior to the second team meeting following the resident's admission. The team met weekly to review the residents and their care plans. All members of the team reported that the care plan worked well and the further development and enhancements of the care plan was discussed by the team at regular intervals. The team had no clinical psychologist and occupational therapy input had been reduced from last year because a post had been lost in the service. Following the inspection, the service reported that the occupational therapy post had been filled in May and a further increase in occupational therapy was due in July 2008.

GOOD PRACTICE DEVELOPMENTS 2008

- A collaborative care plan was introduced for the residents on the first floor.
- A review of the risk assessment tool.
- Training in risk assessment for ward-based staff.
- The service facilitated a conference on social inclusion in mental health.

- The development of a charity focused on recovery and social inclusion and an information resource for other services.

- Review of care planning process in line with the MHC draft Code of Practice on admissions, transfers and discharge.

- One nurse had qualified in Risk Management at postgraduate level.

SERVICE USER INTERVIEWS

Continuing Care: A number of residents were met informally. They expressed general satisfaction with the nursing staff and were aware of their consultant psychiatrist.

Special Care: One of the residents spoke to the Inspectorate. The residents were generally happy with the care and treatment received and felt involved in planning for future treatment. The resident reported that the treatment plan had socialisation and rehabilitation opportunities built in to help keep in touch with living in and returning to the community.

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

1. There should be a rehabilitation team appointed to the service. All the residents on the first floor should have needs assessment completed and appropriate accommodation provided in community-based settings.

2. Funding should be made available to recruit a clinical psychologist.

3. Funding should be made available to ensure that ongoing maintenance and refurbishment of the approved centre is undertaken.

4. The plans to upgrade safety in relation to the visitors room should proceed without delay and the service needs to consider options in relation to possible future use of seclusion. Following inspection the service reported these issues were being followed up.

5. The introduction of integrated notes for each resident that contain the resident's MDT care plan that all disciplines access and record their interventions.

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 19 JUNE 2008

Article 5: Food and Nutrition

The service was compliant.

Compliant: Yes

Article 8: Residents' Personal Property and Possessions

There was a policy in place. A record was kept of personal property and possessions.

Compliant: Yes

Article 11 (1-6): Visits

A policy on visiting was in place.

Continuing Care: All visitors used a room off the ward.

Special Care: A separate visitors rooms was available.

Compliant: Yes

Article 12 (1-4): Communication

A policy that reflected local practice was submitted.

Compliant: Yes

Article 13: Searches

The policy had been compiled, but still needed to be signed off.

Breach: Article 13 (1)

Compliant: No

Article 15: Individual Care Plan

Continuing Care: A collaborative care plan between nursing staff and the resident was introduced since the last inspection. A number were reviewed and were up to date on the day of the inspection. A medical treatment plan was written in the medical notes. The nurse therapy department recorded a six-monthly note in the MDT section of the medical notes. There was no access to health and social care staff. Following inspection, the service reported that MDT input would be addressed, though no details or time frames were given.

Special Care: All residents had individual care plans.

Breach: Article 15 (1st Floor)

Compliant: No

Article 16: Therapeutic Services and Programmes

Continuing Care: The residents had access to nursing staff on a 24-hour basis. Medical staff visited the ward at set intervals. There were three consultant psychiatrists with responsibility for residents on the ward. NCHDs visited on request. Since January 2008 there was no NCHD dedicated to the ward. The junior doctors attached to the forensic team provided this service. There was an unmet need for a rehabilitation team to provide a comprehensive assessment of need and to identify appropriate accommodation needs for the residents.

Residents had access to the nurse therapy department. A number of activities were available on the ward. Individual hobbies were encouraged. Some residents went swimming or played basketball at a local facility. One resident attended a workshop off site.

Following inspection, the service reported that the link between care plans and therapeutic services would be addressed.

Special Care: All residents had access to the forensic team and dedicated nursing staff based on the ward. In addition, the social worker facilitated sessions with family members and there were individual referrals to occupational therapy. Residents had access to a five-day activities programme. Two dedicated nursing staff were assigned to this area. The activities programmes were linked to the individual care plan and recorded in the MDT notes. A socialisation programme was run at weekends for some residents.

Breach: Article 16 (1) (Continuing Care)

Compliant: No

Article 17: Children's Education

It was reported that child admissions were very rare. Arrangements for education were put in place if required.

Compliant: Yes

Article 18: Transfer of Residents

A policy was submitted that referred to the transfer of detained patients. It must include the transfer procedure for all residents. Following the inspection, the service reported that this was being addressed.

Breach: The policy must include all residents [Article 18 (2)].

Compliant: No

Article 19 (1-2): General Health

Continuing Care: The NCHD from the forensic team was responsible for the general health needs of the residents and attended the ward on request. A chiropodist visited monthly. Since the last inspection the physiotherapist had retired. All residents were offered the influenza vaccine. The residents all had physical examinations undertaken every six months. Records of these examinations were available in the case notes. There was a rota in place to ensure compliance. Breast Check was not available in the region at the time of inspection.

Special Care: Routine physical examinations were included as part of the individual's care plan. There was evidence in the clinical files reviewed that six-monthly physical examinations had been completed.

Compliant: Yes

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

Continuing Care: Based on individual needs and understanding it was reported that information was provided in the main verbally by the nursing staff. The residents were aware of all the requirements under this Article. Verbal and written information was provided based on need. The advocacy service attended monthly. A number of voluntary agencies also visited the ward. Details were posted in the day room. Information on medications, including possible side effects, was provided on request.

Special Care: The unit had an information booklet for residents that described the functioning of the unit, the team and general housekeeping arrangements. Information was available on the unit about the Irish Advocacy Network (IAN) and other voluntary agencies. On the day of the inspection, staff reported that written information on diagnosis was not routinely given to residents. The consultant psychiatrist gave information to the residents about medication and possible side effects.

Breach: In the Special Care Unit, written information was not provided to residents on their diagnosis [Article 20 (1)(c)].

Compliant: No

Article 21: Privacy

The service was compliant.

Compliant: Yes

Article 25: Use of Closed Circuit Television (CCTV)

Special Care: On occasion the service had to use the visitors room for seclusion. Staff reported that they were aware of the need to ensure privacy for the residents and in this regard one of the nursing staff took responsibility to ensure that the CCTV monitor in the security office was switched off. This should be included in the CCTV policy. The service was requested to submit an amended CCTV policy to reflect local practice in relation to use of the visitor's room for seclusion but this was not received by the Inspectorate.

Breach: No up-to-date written policy and procedures on CCTV was available.

Compliant: No

Article 28: Register of Residents

The register of residents met the requirements of this Article.

Compliant: Yes

Article 29: Operating policies and procedures

The two policies still outstanding were one on searches, which still needed to be signed off, and risk management. The service was asked to forward the outstanding policies and review of policies procedure to the Inspectorate. The service indicated that work on the outstanding policies was progressing, but gave no information about its procedures for reviewing policies.

Breach: No evidence of a system for reviewing policies and procedures was provided. A policy recommended for review by the Inspectorate in the previous year's report had not been reviewed (wristband policy) and the service indicated it was not due for review until 2010.

Compliant: No

Article 31: Complaint Procedures

A record of complaints was made available to the Inspectorate.

Compliant: Yes

Article 32: Risk Management Procedures

There was no risk management policy in place. The service was requested to submit a risk management policy to the Inspectorate. The service indicated the risk assessment and management policy was being worked on.

Breach: Article 32 (1)

Compliant: No

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

SECLUSION

Special Care: It was reported that there was two recent episodes of seclusion. A report had been sent to the Inspectorate.

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**	Compliant
3	**Patients' dignity and safety**	Compliant
4	**Monitoring of the patient**	Compliant
5	**Renewal of seclusion orders**	Not applicable
6	**Ending seclusion**	Compliant
7	**Facilities**	Non-compliant. The unit had not used seclusion at all until recently when two episodes occurred. The unit did not have designated seclusion facilities. The visitors room was being used as interim measure and some upgrading of the facility was required to enhance the safety of the room. The service had highlighted these issues to the Mental Health Commission prior to the inspection.
8	**Recording**	Non-compliant. The unit did not have a seclusion register but were using the form published in the Rules Governing the Use of Seclusion.
9	**Clinical governance**	Non-compliant. A draft policy was in place, it required signing off.
10	**Staff training**	Non-compliant. Staff were not receiving regular updates in restraint training.
11	**CCTV**	Compliant
12	**Child patients**	Not applicable

Breach: Section 7.1, Section 7.3, Section 7.4, Section 9.1, Section 10

Compliant: No

ECT

The approved centre had no ECT facilities.

Compliant: Not applicable

MECHANICAL RESTRAINT

Staff reported that mechanical restraint was not used on either floor. A policy stating that this was practice was sent to the Inspectorate team as requested.

SECTION	DESCRIPTION	COMPLIANCE REPORT
21	**Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour**	Staff reported that mechanical restraint for enduring self-harm behaviour was not used.

Compliant: Not applicable

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

PHYSICAL RESTRAINT

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**	Non-compliant. An annual report on the use of physical restraint was not available
7	**Staff training**	Non-compliant. The service reported that there was an embargo on CPI training and progress was awaited from the National Working Group on the Management of Violence and Aggression.
8	**Child residents**	Not applicable

Breach: Section 6, Section 7

Compliant: No

ADMISSION OF CHILDREN

There were no children admitted on the day of inspection.

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**	The approved centre should have all the required policies in place in relation to the admission of a child and appropriately trained staff. The approved centre submitted a policy on admission of children, other policies were outstanding.
3	**Treatment**	Not applicable
4	**Leave provisions**	Not applicable

Breach: Section 2.5(a), Section 2.5(e), Section 2.5(i), Section 2.5(l)

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**	Non-compliant. Risk management policy and procedures required.
4	**Clinical governance**	Non-compliant. Risk management policy and procedures required.

Breach: Section 3.1, Section 4

Compliant: No

ECT FOR VOLUNTARY PATIENTS

The approved centre had no ECT facilities.

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

There were no detained patients on the first floor.

Special Care: Section 61 was not applicable. Section 60 was in order in the clinical files.

Compliant: Yes