Report of the Inspector of Mental Health Services 2008

HSE AREA	HSE West
CATCHMENT	Galway West
MENTAL HEALTH SERVICE	Galway West
APPROVED CENTRE	Psychiatric Unit, University College Hospital, Galway
NUMBER OF UNITS OR WARDS	1
UNITS OR WARDS INSPECTED	Psychiatric Unit
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	43
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	12 August 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.

DESCRIPTION

The Psychiatric Unit was located in the main campus of University College Hospital. On the day of the inspection, there were 17 male and 18 female residents, seven of whom were involuntary. A high observation area was being built and was to be completed in late autumn. There had been discussion about amalgamating East and West Galway but the Inspectorate could find no evidence that this had progressed since 2007.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Psychiatric Unit	43	35	Four community-based adult mental health teams and one psychiatry of later life team

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. All residents should have an individual care plan as defined in the Regulations

Outcome: This had been implemented and it was expected to undergo an audit soon.

2. A high observation area must be developed to provide for the needs of a group of residents who have been identified as requiring this facility.

Outcome: Construction of this was almost complete.

MDT CARE PLANS 2008

The approved centre was using multidisciplinary care plans. Residents' needs were assessed and interventions and goals and outcomes were documented. The individual care plans were reviewed at the multidisciplinary team meetings which took place regularly. A summary and action plan was completed at each meeting. The care plans could be enhanced by documenting the multidisciplinary team members who attended meetings and were contributing to the care plan, by facilitating the residents to be more actively involved in their own care plan and signing their care plan. The care planning process could be enhanced by using integrated notes and health and social care professionals recording contemporaneous notes in the clinical files. At the time of inspection health and social care professionals were providing typed summaries of each intervention which often resulted in delays in this information being filed in the clinical charts.

GOOD PRACTICE DEVELOPMENTS 2008

- Construction of the new high observation area was almost complete.
- Multidisciplinary care plans had been developed and were in use.
- ECT had been accredited with ECTAS, the ECT accreditation service linked with the Royal College of Psychiatrists.
- The acute psychiatric unit was accredited with AIMS, the Accreditation for Acute Inpatient Mental Health Service.
- The new outpatient department building had freed space, resulting in less congestion and more space for therapies on the acute unit.

SERVICE USER INTERVIEWS

The Inspectorate spoke with one resident who had requested to be seen. He stated that he was happy with the care he was receiving.

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

1. The individual members of the teams who attend the multidisciplinary team meetings should be documented to demonstrate accountability of care and the degree of multidisciplinary team working that was taking place in the approved centre.

2. The care plans could be enhanced by providing residents with opportunities to be more actively involved in the development and ongoing review and evaluation of their own care plans. Residents could be facilitated to sign their care plans, thereby providing documentation of the level of involvement and collaboration of each resident into the care planning process.

3. Integrated clinical notes should include contemporaneous notes from health and social care professions.

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

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 AUGUST 2008

Article 6 (1-2) Food Safety

The food safety report was inspected and a copy was given to the Inspectorate. The service was asked to provide written evidence to the Inspectorate demonstrating what actions had been taken to remedy the unsatisfactory matters listed in the food safety report but failed to do so.

Breach: The food safety report highlighted areas of concern. [Article 6 (1)(a) and Article 6 (1)(c)]

Compliant: No

Article 7: Clothing

Residents who needed to be nursed in night clothes had this documented in their care plan. There was a policy on clothing.

Compliant: Yes

Article 15: Individual Care Plan

Residents had an individual care plan as defined in the Regulations.

Compliant: Yes

Article 16: Therapeutic Services and Programmes

Each resident had access to a range of therapeutic services and programmes which were linked to their individual care plan. Health and social care professions were actively involved in providing therapeutic services on the unit.

Compliant: Yes

Article 17: Children's Education

The unit had made arrangements, through an agreed policy with St. Anne's Child and Adolescent Unit, for the education of children to be facilitated where appropriate.

Compliant: Yes

Article 18: Transfer of Residents

The service was compliant.

Compliant: Yes

Article 19 (1-2): General Health

Each resident had a general health review at admission. Residents were facilitated to attend outpatient appointments with other medical specialists as necessary. One resident had been on the unit for a period in excess of six months and a routine physical examination had been completed.

Compliant: Yes

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

Written information was available on the unit for residents in relation to their diagnosis. Information on medication, including side effects, was also provided to residents. A policy was in place.

Compliant: Yes

Article 21: Privacy

The service was compliant.

Compliant: Yes

Article 22: Premises

Requests for routine maintenance were sent electronically on the P-MAX system. It was reported to the Inspectorate that the maintenance was carried out within 24 hours.

It was envisaged that with the imminent opening of the new high observation area that the problems encountered with the observation of residents due to the design of the unit would be rectified in the near future.

Breach: Article 22 (3)

Compliant: No

Article 25: Use of Closed Circuit Television (CCTV)

CCTV was not used in the approved centre.

Compliant: Not applicable

Article 26: Staffing

The HSE policies on the selection, recruitment and vetting of staff were used. A multidisciplinary staff mix was available to the unit. The duty book recorded the staff on duty and in charge of the centre and a copy was also kept in the assistant director of nursing's office. There was a CNM3 who coordinated training information for

nursing staff. Nursing staff were supported to undertake additional training and qualifications. Some 38 staff had completed training in CPI, which was continuing.

The following table provides a summary of the current unit staffing levels.

STAFF TYPE	DAY	EVENING	NIGHT
Nurse	10 minimum (including CNM2)	6	6
Occupational therapist	1	0	0
Ward clerk	1	0	0

Compliant: Yes

Article 31: Complaint Procedures

The complaints procedure was outlined in the information booklet given to residents at admission. A designated complaints officer was identified. A complaints policy was in use. A record of complaints was inspected.

Compliant: Yes

Article 32: Risk Management Procedures

Incidents were recorded in an incident book and a copy sent to the director of nursing and clinical director, who signed it. A Functional Analysis of Care Environment (FACE) risk management tool had been implemented and was due for audit. A risk management policy was in place. Documentation was made available to the Inspectorate showing identification of risks and precautions put in place to control for such risks, including those specified in this Article.

Compliant: Yes

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

SECLUSION

The seclusion register and a number of clinical charts were reviewed.

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**	Non-compliant. There was no record in the clinical files reviewed that patients had been informed about the reason for and likely duration of seclusion [Section 2.9] or that any action in relation to informing next of kin had been implemented [Section 2.10]. The seclusion register was in order apart from one episode of seclusion carried out by staff from St Anne's Children's Centre who had been asked to submit a photocopy of the completed form to the Inspectorate but have not done so.
3	**Patients' dignity and safety**	Compliant
4	**Monitoring of the patient**	Compliant
5	**Renewal of seclusion orders**	Compliant
6	**Ending seclusion**	Compliant
7	**Facilities**	Compliant. An interim room was being used for seclusion, until the opening of the high observation area, that allowed easy observation and access to toilet and washing facilities.
8	**Recording**	Compliant
9	**Clinical governance**	Compliant. The Inspectorate draws attention to the requirement that the policy on seclusion is reviewed at least annually [Section 9.1(d)].
10	**Staff training**	Non-compliant. Records of staff training were not made available to the Inspectorate.
11	**CCTV**	Not applicable
12	**Child patients**	Not applicable

Breach: There was no record in the clinical files reviewed that patients had been informed about the reason for and likely duration of seclusion [Section 2.9] or that any action in relation to informing next of kin had been implemented [(Section 2.10]. Records of staff training were not made available to the Inspectorate [Section 10].

Compliant: No

ECT

The ECT facilities complied with the requirements of the Rules Governing the Use of ECT and the service had received Electroconvulsive Therapy Accreditation Service (ECTAS) approval. No detained patients had received ECT since January 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**	Not applicable
3	**Information**	Compliant
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**	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

The Inspectorate was informed that mechanical restraint, including mechanical restraint for enduring self-harm behaviour, was not used and the service provided a written statement to this effect.

Compliant: Not applicable

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

PHYSICAL RESTRAINT

The physical restraint register and a number of clinical files were reviewed. The register was completed in full. 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**	Non-complaint. The physical restraint register was in order. The clinical files reviewed did not document that a registered medical practitioner had been informed or that the consultant had been informed [Section 2.6 and Section 2.7]. There was no documentation of next of kin having been informed [Section 2.10].
3	**Resident dignity and safety**	Compliant
4	**Ending physical restraint**	Compliant
5	**Recording use of physical restraint**	Non-compliant
6	**Clinical governance**	Complaint. The Inspectorate draws attention to the requirement in Section 6.1(b) that the policy be reviewed at least annually.
7	**Staff training**	Non-compliant. Staff training records were not made available to the Inspectorate.
8	**Child residents**	Compliant

Breach: The clinical files reviewed did not document that a registered medical practitioner had been informed or that the consultant had been informed [Section 2.6, Section 2.7]. There was no documentation of next of kin having been informed [Section 2.10]. Staff training records were not made available to the Inspectorate [Section 7].

Compliant: No

ADMISSION OF CHILDREN

Children who were admitted were provided with one-to-one nursing. The approved centre had established good working relationships with the local child and adolescent teams.

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 did not provide age appropriate facilities. [Section 2 (5) (b)]
3	**Treatment**	Compliant
4	**Leave provisions**	Compliant

Breach: The approved centre did not provide age appropriate facilities [Section 2.5(b)].

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**	Non-compliant. Policy did not include the information outlined in Section 4.2 and Section 4.3.

Breach: Section 4.2 and Section 4.3

Compliant: No

ECT FOR VOLUNTARY PATIENTS

One voluntary patient had received ECT since January 2008. The clinical file was reviewed.

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 61 was not applicable as all children had been voluntary admissions. One patient was subject to Section 60 and the documentation in the clinical file was in order.

Compliant: Yes