Report of the Inspector of Mental Health Services 2013

EXECUTIVE CATCHMENT AREA/INTEGRATED SERVICE AREA	Carlow, Kilkenny, South Tipperary (CKST)
HSE AREA	South
MENTAL HEALTH SERVICE	Carlow, Kilkenny, South Tipperary
APPROVED CENTRE	Department of Psychiatry, St. Luke's Hospital, Kilkenny
NUMBER OF WARDS	1
NAMES OF UNITS OR WARDS INSPECTED	Department of Psychiatry (DOP)
TOTAL NUMBER OF BEDS	44
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	12 March 2013

Summary

- The DOP Kilkenny a 44-bed acute unit provided mental health care for the Carlow, Kilkenny and South Tipperary catchment area.
- There had been two fatal incidents within the approved centre in 2012 and both involved ligature points. On the day of inspection the two ligature points remained unchanged. On inquiry by inspectors, management subsequently advised that post incidents reviews had taken place and where recommendations were made processes had been put in place to address those recommendations. A ligature audit in relation to these two areas was completed and management reported that both ligature points were removed.
- The admission assessments done by the non consultant hospital doctors were not of a good standard. A number of key areas of assessment were missing and documentation was poor. This was the second successive year that the standards of the Code of Practice on Admission, Transfer and Discharge were not met by the approved centre.
- The individual care plans did not meet the requirements of Article 15 of the Regulations.
- Overall, the DOP sought to provide Recovery oriented care and treatment with a strong community care-pathway.

OVERVIEW

In 2013, the Inspectorate inspected this Approved Centre against all of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

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 2012. In addition to the core inspection process information was also gathered from advocacy reports, service user interviews, staff interviews and photographic evidence collected on the day of the inspection.

DESCRIPTION

The Department of Psychiatry (DOP) was located at St. Lukes Hospital, Kilkenny. The DOP comprised a single story building which could be accessed via its own halldoor entrance near the public car park or via the attached main hospital building. The DOP opened in 2003 and was bright and modern in appearance and surrounded by well landscaped gardens which were popular and well utilised by residents. Fencing and shrubbery provided screening for the unit, which comprised a 19-bed acute area and a 25-bed sub-acute area. The acute area had a high observation section with a seclusion room and three single bedrooms.

There were a large number of consultant psychiatrist led teams admitting to the approved centre: eight sector teams, two psychiatry of old age teams and two rehabilitation and recovery team. Residents from South Tipperary were looked after by the clinical director during their admission. Admission arrangements meant that there were four multidisciplinary team (MDT) review meetings per week within the DOP and four MDT review meetings off-site. On the day of inspection there were 15 residents in the acute area, six of whom were detained patients; 23 residents in the sub-acute area, five of whom were detained. In all, there were 11 detained patients, four of whom were on approved leave in the community.

SUMMARY OF COMPLIANCE WITH MENTAL HEALTH ACT 2001 (APPROVED CENTRES) REGULATIONS 2006

COMPLIANCE RATING	2011	2012	2013	ARTICLE NUMBERS 2013
Fully Compliant	28	24	25	-
Substantial Compliance	2	5	4	16, 21, 22, 26
Minimal Compliance	0	0	1	15
Not Compliant	0	2	0	-
Not Applicable	1	0	1	25

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

DETAILS OF WARDS IN THE APPROVED CENTRE

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
DOP	44	38	8 General Adult teams 2 Psychiatry of Old Age teams 2 Rehabilitation teams

QUALITY INITIATIVES 2012/2013

- There were daily morning meetings with the consultant psychiatrists and nursing management to review the approved centre's activity. The Department of Psychiatry has become the approved centre for the expanded catchment area of Carlow/Kilkenny/South Tipperary (CKST).
- A new Integrated Governance Framework had been developed to oversee strategy, governance and operations of the expanded catchment area
- All referrals to the Community Mental Health Team (CMHT) were through 'A single point of entry' which had been clearly identified to primary care services. A process of triage occurred and GP's could expect a prompt response to all urgent referrals.
- Further development of the Home Based Treatment and acute day services in CKST had resulted in a reduction in admission rates to the approved centre.
- A programme of training in record keeping and standards had commenced in the DOP.
- A CLASS (Carers Liaison And Support Service) had been formed which aimed to provide peer support to carers, relatives or friends who were experiencing a mental health crisis with their loved one.
- A staff nurse was trained in palliative care and was a committee member on both St Luke's Hospital and the national committee for End Of Life Care.

PROGRESS ON RECOMMENDATIONS IN THE 2012 APPROVED CENTRE REPORT

1. Each resident must have an individual care plan as described in the Regulations.

Outcome: Each resident had an individual care plan (ICP), however, the quality of ICPs was very variable.

2. The approved centre must ensure full compliance with the Rules Governing the Use of Seclusion.

Outcome: This has been achieved.

3. Each resident must have a physical examination at least every six months.

Outcome: Six-month physical examinations had been completed and were well recorded in the individual clinical files.

4. Any resident wearing night clothes during the day should have the reasons clearly documented in their individual care plan.

Outcome: Where a resident was required to wear night attire as part of the individual care plan, this was recorded in the individual clinical file. Several residents were wearing night attire, by their own choice, at the time of inspection and inspectors recommended that this be recorded also.

5.The approved centre should ensure all residents have privacy in their bedrooms.

Outcome: The single rooms did not provide adequate privacy for residents because the door panels were of clear glass and residents were visible from the corridor. The approved centre had sourced and priced replacement window panels with inbuilt blinds and funding approval was now in place to proceed.

6. The approved centre must be adequately staffed with health and social care professionals.

Outcome: All teams were not adequately staffed. There was no evidence of psychology input in the clinical files.

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

The registered proprietor shall make arrangements to ensure that each resident is readily identifiable by staff when receiving medication, health care or other services.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Two nurses administered medication. There was a clear key-working nursing system in place and a robust handover system and therefore all residents were known to staff.

Article 5: Food and Nutrition

(1) The registered proprietor shall ensure that residents have access to a safe supply of fresh drinking water.

(2) The registered proprietor shall ensure that residents are provided with food and drink in quantities adequate for their needs, which is properly prepared, wholesome and nutritious, involves an element of choice and takes account of any special dietary requirements and is consistent with each resident's individual care plan.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Fresh drinking water was available throughout the approved centre. Food was prepared at the kitchen in St. Canice's Hospital and delivered in heated trolleys to the DOP. There was a menu posted which featured an eight-week menu rotation and provided an adequate choice of meals. The main meal served at lunch featured freshly prepared meat or fish and vegetables and fruit. The evening meal appeared to rely more heavily on processed foods such as sausages, sausage rolls, chicken pies and fried food, however, a healthy option could be pre-ordered also.

Article 6 (1-2): Food Safety

(1) The registered proprietor shall ensure:

(a) the provision of suitable and sufficient catering equipment, crockery and cutlery

(b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and

(c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.

(2) This regulation is without prejudice to:

(a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;

(b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and

(c) the Food Safety Authority of Ireland Act 1998.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The most recent Environmental Health Officer's report of February 2013 was available for inspection. A number of minor issues relating to the upkeep of the fabric of the building had been identified and were due to be rectified.

Article 7: Clothing

The registered proprietor shall ensure that:

(1) when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;

(2) night clothes are not worn by residents during the day, unless specified in a resident's individual care plan.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X		X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*		X	
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a supply of clothing available in the event of an individual not having personal clothing on admission. Two residents in the acute area were dressed in night attire as a precaution to reduce the risk of absconsion and this was documented in the individual clinical files.

Several residents were wearing night attire by their own choice. Inspectors recommended that a record sheet be included in the individual clinical files for ease of recording the reason why a resident was dressed in night clothes.

Article 8: Residents' Personal Property and Possessions

(1) For the purpose of this regulation "personal property and possessions" means the belongings and personal effects that a resident brings into an approved centre; items purchased by or on behalf of a resident during his or her stay in an approved centre; and items and monies received by the resident during his or her stay in an approved centre.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures relating to residents' personal property and possessions.

(3) The registered proprietor shall ensure that a record is maintained of each resident's personal property and possessions and is available to the resident in accordance with the approved centre's written policy.

(4) The registered proprietor shall ensure that records relating to a resident's personal property and possessions are kept separately from the resident's individual care plan.

(5) The registered proprietor shall ensure that each resident retains control of his or her personal property and possessions except under circumstances where this poses a danger to the resident or others as indicated by the resident's individual care plan.

(6) The registered proprietor shall ensure that provision is made for the safe-keeping of all personal property and possessions.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

A property check-list was completed at the time of admission and was signed by the nurse and the resident if they so wished. A copy of the property list was kept in the individual clinical file.

The approved centre had written operational policies and procedures in place in relation to residents' property and possessions. There was provision for safe keeping if required and all residents had adequate personal storage space beside their bed.

Article 9: Recreational Activities

The registered proprietor shall ensure that an approved centre, insofar as is practicable, provides access for residents to appropriate recreational activities.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There were televisions, DVD players, newspapers, table games, art materials, table-tennis and mini-football table available for residents. The garden area was spacious and attractively landscaped and was much used and valued by residents.

Article 10: Religion

The registered proprietor shall ensure that residents are facilitated, insofar as is reasonably practicable, in the practice of their religion.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The approved centre had policies and practices in place to ensure residents of all faiths were facilitated in the practice of their religion insofar as practicable.

Article 11 (1-6): Visits

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.

(2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.

(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.

(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident's individual care plan.

(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.

(6) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was an up-to-date policy on visits. Although there were specified visiting times, there was reasonable flexibility with regard to this. There was no dedicated visiting room but a quiet room and an office space were available for use. The policy made provision for children visiting despite this there was a sign stating no child visitors in the acute area. Staff stated that children could visit accompanied by a responsible adult and were facilitated in a room outside the acute area.

Article 12 (1-4): Communication

(1) Subject to subsections (2) and (3), the registered proprietor and the clinical director shall ensure that the resident is free to communicate at all times, having due regard to his or her wellbeing, safety and health.

(2) The clinical director, or a senior member of staff designated by the clinical director, may only examine incoming and outgoing communication if there is reasonable cause to believe that the communication may result in harm to the resident or to others.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on communication.

(4) For the purposes of this regulation "communication" means the use of mail, fax, email, internet, telephone or any device for the purposes of sending or receiving messages or goods.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was an up-to-date policy on communication. Two of the public telephones had been decommissioned and one public telephone was available for use in the acute area and residents were also facilitated with the use of an office telephone. Whilst residents in the acute area did not retain their personal mobile telephones, if clinically indicated, they had access to and use of their mobile telephone on request. Residents in the sub-acute area could retain their personal mobile telephones unless clinically counter-indicated.

Article 13: Searches

(1) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated.

(2) The registered proprietor shall ensure that searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for carrying out searches with the consent of a resident and carrying out searches in the absence of consent.

(4) Without prejudice to subsection (3) the registered proprietor shall ensure that the consent of the resident is always sought.

(5) The registered proprietor shall ensure that residents and staff are aware of the policy and procedures on searching.

(6) The registered proprietor shall ensure that there is be a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

(7) The registered proprietor shall ensure that all searches are undertaken with due regard to the resident's dignity, privacy and gender.

(8) The registered proprietor shall ensure that the resident being searched is informed of what is happening and why.

(9) The registered proprietor shall ensure that a written record of every search is made, which includes the reason for the search.

(10) The registered proprietor shall ensure that the approved centre has written operational policies and procedures in relation to the finding of illicit substances.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Residents possessions were searched at the time of admission to ensure resident health and wellbeing. There was an up-to-date policy on searches with and without permission and on the finding of illicit substances. There had been no searches carried out in relation to current residents. The approved centre had acquired a new drug screening machine and staff reported that this was therapeutically helpful, was used judiciously and where screening was indicated that a resident provided consent.

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

(1) The registered proprietor shall ensure that the approved centre has written operational policies and protocols for care of residents who are dying.

(2) The registered proprietor shall ensure that when a resident is dying:

(a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;

(b) in so far as practicable, his or her religious and cultural practices are respected;

(c) the resident's death is handled with dignity and propriety, and;

(d) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:

(a) in so far as practicable, his or her religious and cultural practices are respected;

(b) the resident's death is handled with dignity and propriety, and;

(c) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(4) The registered proprietor shall ensure that the Mental Health Commission is notified in writing of the death of any resident of the approved centre, as soon as is practicable and in any event, no later than within 48 hours of the death occurring.

(5) This Regulation is without prejudice to the provisions of the Coroners Act 1962 and the Coroners (Amendment) Act 2005.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a policy on the care of residents who are dying. Single room accommodation was available for a resident who was dying, however, residents were usually transferred over to the general hospital. There had been no deaths within the approved centre in 2013 up to the time of inspection.

Article 15: Individual Care Plan

The registered proprietor shall ensure that each resident has an individual care plan.

[Definition of an individual care plan:"... a documented set of goals developed, regularly reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation".]

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X		
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			X
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*		X	

Justification for this rating:

Each resident had an individual care plan (ICP), however, the quality of the recorded ICPs was generally poor and sketchy. There was good detail recorded elsewhere in the progress notes, including identification of psychosocial issues, family input, multidisciplinary input and overall progress. The quality of ICPs appeared to be compromised by a couple of factors: the ICP was not just being reviewed but was being rewritten at each weekly multidisciplinary (MDT) meeting and was recorded in a tokenistic manner. The rewriting was tedious and unnecessary with the upshot that the ICPs were generally thin on clear goals, identified responsible clinician and outcomes achieved. For example, in one ICP, a planned intervention was fluid intake and this was tasked to the MDT, in another ICP the only identified need recorded was "no compliance with medication" and "hours out", with "review" as the stated intervention. Despite the inadequate recording of ICPs there was evidence of good interdisciplinary working and a care pathway with an emphasis on the community.

Inspectors recommended that the approved centre ensure that: the ICP template include identified needs, goals, planned interventions and clinician responsible for delivery, review and outcome; the ICP should be updated in a timely and effective manner so as to track progress across the

multifaceted domains of care.

Breach: 15

Article 16: Therapeutic Services and Programmes

(1) The registered proprietor shall ensure that each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan.

(2) The registered proprietor shall ensure that programmes and services provided shall be directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X		
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*		X	

Justification for this rating:

There was a core therapeutic day timetabled for residents and this comprised groups and activities run by the occupational therapist assigned full-time to the unit and by a sessional art therapist and nursing staff. The programme included activities addressing physical and psychosocial health and wellbeing. A referral form had been introduced whereby the MDT might refer individual residents to named groups. All groups were open to all residents. It was clear that staff had put time and effort into drawing up a timetable of activities, which included, domestic skills training, self esteem, conflict resolution, relaxation, stress management, pre-discharge planning, art class, exercises, among the options. The ICPs did not adequately specify the therapeutic interventions required based on the assessed needs of the resident. Therefore, it was not evident that the programmes delivered were of individual relevance or benefit to residents other than providing a structured social environment, activation and diversion.

The occupational therapist (OT) wrote a brief and generic note recording residents' attendance, participation and general demeanour in groups. Whilst that was good, there was no occupational therapy report as such available for any of the persons resident in the approved centre on the day of inspection.There was a fully equipped activities of daily living (ADL) kitchen facility but it appeared to be little used. None of the residents had been assessed in terms of their functional ability in the occupations of daily living such as self care/ADL, productivity and leisure. The OT evidently worked

hard and was committed to providing a full activities programme but this was at the cost of an occupational therapy service.

There was evidence of social work input to residents in the approved centre recorded in the individual clinical files. Inspectors did not find any recorded clinical psychology input.

The therapeutic services and programmes provided within the DOP should be based on assessed needs and elucidated in the ICPs.

Breach: 16.1

Article 17: Children's Education

The registered proprietor shall ensure that each resident who is a child is provided with appropriate educational services in accordance with his or her needs and age as indicated by his or her individual care plan.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	**NOT APPLICABLE**	**X**	**X**
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was no child resident on the day of inspection. No educational facilities had been required for the child admissions within the previous twelve months but there was a contingency plan to provide such arrangements should the need arise.

Article 18: Transfer of Residents

(1) When a resident is transferred from an approved centre for treatment to another approved centre, hospital or other place, the registered proprietor of the approved centre from which the resident is being transferred shall ensure that all relevant information about the resident is provided to the receiving approved centre, hospital or other place.

(2) The registered proprietor shall ensure that the approved centre has a written policy and procedures on the transfer of residents.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a policy on the transfer of residents. There was an excellent nursing transfer form and a medication sheet which accompanied residents on transfer and the treating doctor also provided a written medical referral.

Article 19 (1-2): General Health

(1) The registered proprietor shall ensure that:

(a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;

(b) each resident's general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;

(c) each resident has access to national screening programmes where available and applicable to the resident.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for responding to medical emergencies.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X		X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*		X	
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a policy on responding to medical emergencies. Residents had access to general health screening programmes where required. One patient had been resident in the approved centre for a period in excess of six months and a physical health review had been completed for this individual.

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

(1) Without prejudice to any provisions in the Act the registered proprietor shall ensure that the following information is provided to each resident in an understandable form and language:

(a) details of the resident's multi-disciplinary team;

(b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;

(c) verbal and written information on the resident's diagnosis and suitable written information relevant to the resident's diagnosis unless in the resident's psychiatrist's view the provision of such information might be prejudicial to the resident's physical or mental health, well-being or emotional condition;

(d) details of relevant advocacy and voluntary agencies;

(e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

(2) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for the provision of information to residents.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was an up-to-date policy on the provision of information to residents. There was an information leaflet for residents and families about the DOP. There was a resource room for residents which provided access to the Orchid project, an intranet facility which provided information on medications and diagnoses. There was information posted throughout the unit on independent advocacy services. The notice board in the sub-acute section of the unit provided excellent information and posters about voluntary groups and activities in the community, including a men's shed support group, and

conveyed an outward looking community and recovery oriented culture within the approved centre.

Article 21: Privacy

The registered proprietor shall ensure that the resident's privacy and dignity is appropriately respected at all times.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*			
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*	X	X	X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

On the day of inspection, the window panels in the single room doors were not occluded and residents did not have adequate privacy. Staff reported that plans were at an advanced stage to install replacement windows with inbuilt blinds. In the meantime, a privacy film should be applied to the relevant window panels.

Breach: 21

Article 22: Premises

(1) The registered proprietor shall ensure that:

(a) premises are clean and maintained in good structural and decorative condition;

(b) premises are adequately lit, heated and ventilated;

(c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

(2) The registered proprietor shall ensure that an approved centre has adequate and suitable furnishings having regard to the number and mix of residents in the approved centre.

(3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff and visitors.

(4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose in so far as it practicable and in accordance with best contemporary practice.

(5) Any approved centre in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall ensure that the buildings are, as far as practicable, accessible to persons with disabilities.

(6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and 2001, Part M of the Building Regulations 1997, the Disability Act 2005 and the Planning and Development Act 2000.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X		
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*		X	X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The approved centre was a bright modern single story building which had opened in 2003. Maintenance requirements were routinely referred to and discussed with technical services. Floor covering was replaced in the kitchen and the main corridor in the sub acute area of the unit. In the acute area of the unit the seclusion room, room 14 and below the dado rail were painted within the last twelve months.

The wear and tear, however, was evident in some areas with floor covering and walls being marked and grubby. There were small sitting room areas which provided limited seating. There were insufficient numbers of chairs for the numbers of residents and the chairs were badly worn. Little attention appeared to have been paid to decor in recent years.

There were two ligature points evident during the inspection. One was the door of one of the toilets in the sub-acute area and the other ligature point was the handle of the door inside the ensuite in a single room. There had been two incidents concerning these ligature points that had been notified to the Mental Health Commission prior to inspection.

Breach: 22 (1)(a), 22 (2) (3)

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

(1) The registered proprietor shall ensure that an approved centre has appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.

(2) This Regulation is without prejudice to the Irish Medicines Board Act 1995 (as amended), the Misuse of Drugs Acts 1977, 1984 and 1993, the Misuse of Drugs Regulations 1998 (S.I. No. 338 of 1998) and 1993 (S.I. No. 338 of 1993 and S.I. No. 342 of 1993) and S.I. No. 540 of 2003, Medicinal Products (Prescription and control of Supply) Regulations 2003 (as amended).

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The approved centre had up-to-date policies on the ordering, prescribing, storing and administration of medicines.

Article 24 (1-2): Health and Safety

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the health and safety of residents, staff and visitors.

(2) This regulation is without prejudice to the provisions of Health and Safety Act 1989, the Health and Safety at Work Act 2005 and any regulations made thereunder.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a Health and Safety statement and policies and procedures relating to residents, staff and visitors.

Article 25: Use of Closed Circuit Television (CCTV)

(1) The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:

(a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

(b) it shall be clearly labelled and be evident;

(c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;

(d) it shall be incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;

(e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

(2) The registered proprietor shall ensure that the existence and usage of closed circuit television or other monitoring device is disclosed to the resident and/or his or her representative.

(3) The registered proprietor shall ensure that existence and usage of closed circuit television or other monitoring device is disclosed to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the approved centre or at anytime on request.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was an up-to-date policy in relation to CCTV which was used in the seclusion room only and this was well signposted.

Article 26: Staffing

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.

(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.

(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.

(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.

(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.

(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

WARD OR UNIT	STAFF TYPE	DAY	NIGHT
DOP Acute Area	CNM3	Shared 1	0
	Acting CNM3	0	Shared 1
	CNM 2	1	1
	RPN	4	3
DOP Sub-Acute Area	CNM 2	1	0
	RPN	4	2

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Non Consultant Hospital Doctor (NCHD),Director of Nursing, (DON), Assistant Director of Nursing (ADON).

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*			
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*	X	X	X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The Health Service Executive policies and procedures on the recruitment of staff applied. The staff training record was up to date.

The multidisciplinary teams admitting residents to the DOP were not fully staffed and this resulted in health and social care professionals having to work across teams which meant that the skill mix and number of staff was not adequate to meet the assessed needs of residents. There was an assistant director of nursing in charge of the DOP.

Breach: 26 (2)

Article 27: Maintenance of Records

(1) The registered proprietor shall ensure that records and reports shall be maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. All records shall be kept up-to-date and in good order in a safe and secure place.

(2) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the creation of, access to, retention of and destruction of records.

(3) The registered proprietor shall ensure that all documentation of inspections relating to food safety, health and safety and fire inspections is maintained in the approved centre.

(4) This Regulation is without prejudice to the provisions of the Data Protection Acts 1988 and 2003 and the Freedom of Information Acts 1997 and 2003.

The Inspectorate did not inspect and has no expertise in assessing fire risk

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was an up-to-date policy on records. The environmental health and fire inspection reports were available for inspection. Staff had completed fire drills and fire safety training. All required policies and procedures were up to date. The clinical files were generally well maintained.

Article 28: Register of Residents

(1) The registered proprietor shall ensure that an up-to-date register shall be established and maintained in relation to every resident in an approved centre in a format determined by the Commission and shall make available such information to the Commission as and when requested by the Commission.

(2) The registered proprietor shall ensure that the register includes the information specified in Schedule 1 to these Regulations.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The Register of Residents met the requirements of the Regulations.

Article 29: Operating policies and procedures

The registered proprietor shall ensure that all written operational policies and procedures of an approved centre are reviewed on the recommendation of the Inspector or the Commission and at least every 3 years having due regard to any recommendations made by the Inspector or the Commission.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

All policies and procedures were in date.

Article 30: Mental Health Tribunals

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.

(2) In circumstances where a patient's condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The DOP cooperated fully with Mental Health Tribunals and facilitated patients to attend where required. An appropriate room was provided for Mental Health Tribunals.

Article 31: Complaint Procedures

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre.

(2) The registered proprietor shall ensure that each resident is made aware of the complaints procedure as soon as is practicable after admission.

(3) The registered proprietor shall ensure that the complaints procedure is displayed in a prominent position in the approved centre.

(4) The registered proprietor shall ensure that a nominated person is available in an approved centre to deal with all complaints.

(5) The registered proprietor shall ensure that all complaints are investigated promptly.

(6) The registered proprietor shall ensure that the nominated person maintains a record of all complaints relating to the approved centre.

(7) The registered proprietor shall ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.

(8) The registered proprietor shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

(9) This Regulation is without prejudice to Part 9 of the Health Act 2004 and any regulations made thereunder.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The complaints procedure was clearly displayed and was also detailed in the DOP information leaflet. There was an identified person within the DOP charged with dealing with complaints. There was an up-to-date policy on dealing with complaints. The complaints log was inspected and in order.

Article 32: Risk Management Procedures

(1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:

(a) The identification and assessment of risks throughout the approved centre;

(b) The precautions in place to control the risks identified;

(c) The precautions in place to control the following specified risks:

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;

(e) Arrangements for responding to emergencies;

(f) Arrangements for the protection of children and vulnerable adults from abuse.

(3) The registered proprietor shall ensure that an approved centre shall maintain a record of all incidents and notify the Mental Health Commission of incidents occurring in the approved centre with due regard to any relevant codes of practice issued by the Mental Health Commission from time to time which have been notified to the approved centre.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The risk management policy and procedures met the requirements of the Regulations. Risk assessment was completed at the time of admission and updated as indicated. A standardised risk assessment tool was used. The risk assessment and management plan was generally well filled out and incorporated the resident's strengths, supports and vulnerabilities.

In one individual clinical file inspected the risk assessment and management record was not adequately completed. The pre-admission general practitioner record identified high suicide risk and family collateral confirmed this. It was evidently the admitting doctor's clinical opinion that this was not a risk but the admission assessment did not elucidate and there was no explanation as to whether/how this risk had altered or been ameliorated. The individual care plan recorded "safety" as a need but this was inadequately spelt out both in terms of reason and management plan. Other than this instance, all other risk assessments inspected were of a good standard.

There had been two fatal incidents within the approved centre in 2012 and both involved ligature points. On the day of inspection the two ligature points remained unchanged. On inquiry by inspectors, subsequently management advised that post incidents reviews had taken place and where recommendations were made processes had been put in place to address those recommendations. A ligature audit in relation to these two areas was completed resulting in both ligature points being removed.

Management also reported that as a result of previous ligature audits straps were removed from mattresses, shower heads were changed, collapsible curtain rails and wardrobe rails were installed, and hooks for curtain tiebacks were removed from the bedrooms. Outside external pipes in the acute unit's garden were boxed in.

There was an identified risk manager with responsibility for mental health services.There was a clinical governance process in place to review incidents. Deaths and incidents were reported to the Mental Health Commission.

Article 33: Insurance

The registered proprietor of an approved centre shall ensure that the unit is adequately insured against accidents or injury to residents.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The insurance certificate was provided for inspection.

Article 34: Certificate of Registration

The registered proprietor shall ensure that the approved centre's current certificate of registration issued pursuant to Section 64(3)(c) of the Act is displayed in a prominent position in the approved centre.

LEVEL OF COMPLIANCE	DESCRIPTION	2011	2012	2013
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The Certificate of Registration was displayed in the entrance hallway to the DOP.

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

SECLUSION

Use: Seclusion was used in the approved centre

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

Justification for this rating:

The seclusion area was satisfactory and was safe. A care plan for seclusion was in operation. There was evidence that the monitoring of the resident in seclusion was adequate.

The seclusion register was correctly completed. Next of kin were informed of the seclusion episode where appropriate. Where next of kin were not informed the reason why was documented.

Seclusion episodes were discussed with the resident and at the following multidisciplinary team meeting.

There was a policy regarding seclusion.

Electroconvulsive Therapy (ECT) (DETAINED PATIENTS)

Use: One patient had initially received ECT whilst of detained status. Their detention order was revoked during the programme of ECT following which they consented to ECT.

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

Justification for this rating:

One patient had initially received ECT whilst detained. Their detention order was revoked during the programme of ECT following which they consented to ECT. Form 16 was correctly completed. Ongoing cognitive assessments were performed.

The ECT suite was in good condition and all materials and equipment were available. There was a good information booklet about ECT.

There was a nominated consultant psychiatrist and anaesthetist for ECT and an ECT nurse.

ECT was prescribed in the clinical file.

MECHANICAL RESTRAINT

Mechanical Restraint was not used in the approved centre.

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

PHYSICAL RESTRAINT

Use: Physical restraint was used in the approved centre.

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

Justification for this rating:

Seven clinical files of residents who were physically restrained and the Physical Restraint Clinical Practice Form book were examined. All episodes were documented in the clinical files. Next of kin were informed. The episodes of physical restraint were discussed with the resident and were also discussed at the multidisciplinary team meetings.

One clinical practice form had not been signed by the consultant psychiatrist. The Inspectorate were informed that there was a disagreement about which consultant psychiatrist was responsible for signing the form and that this was under discussion with the clinical director.

Breach: 5.7 (c)

ADMISSION OF CHILDREN

Description: There was no child resident in the approved centre on the day of inspection.

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

Justification for this rating:

The approved centre was not suited to the admission of children.

One child had been admitted and discharged in 2013 and this individual clinical file was inspected. There was an individual care plan and risk assessment was completed. Parental consent was provided. The DOP notified the Mental Health Commission about the admission of the child and reported that no bed was available at the time in a child and adolescent approved centre. The DOP had a policy on the admission of a child.

Breach: 2.5

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

Description: The death had occurred at home of a person discharged some 24 hours previously from the approved centre.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
2	**Notification of deaths**	X			
3	**Incident reporting**	X			
4	**Clinical governance (identified risk manager)**	X			

Justification for this rating:

One person who had been in-patient in 2013 had died soon after discharge and this death was notified to the Mental Health Commission. An external review of this death was underway. There had been two deaths within the DOP in the preceding year and an external review was underway in relation to both deaths. The DOP maintained a log of incidents and reported incidents on a six monthly basis to the Mental Health Commission. There was a clinical governance committee within the DOP and incidents were reviewed regularly.

Electroconvulsive Therapy (ECT) FOR VOLUNTARY PATIENTS

Use: One patient had initially received ECT whilst of detained status. Their detention order was revoked during the programme of ECT following which they consented to ECT and received the remainder of their programme of ECT as a voluntary patient.

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

Justification for this rating:

The ECT suite was in good condition and all materials and equipment were available. There was a good information booklet about ECT.

There was a nominated consultant psychiatrist and anaesthetist for ECT, and an ECT nurse.

ECT was prescribed in the clinical file. Ongoing cognitive assessments were performed and documented in the clinical file.

ADMISSION, TRANSFER AND DISCHARGE

Part 2 Enabling Good Practice through Effective Governance

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

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
X			

Justification for this rating:

There were policies regarding admission, transfer and discharge. The approved centre was fully compliant with Article 19 on the Transfer of Residents and with Article 32 on Risk Management. Staff roles were clearly assigned and a key worker system was in place. There were policies on privacy, confidentiality and consent.

Part 3 Admission Process

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

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
	X		

Justification for this rating:

Psychiatric assessment on admission was inadequate in a number of clinical files. In one assessment there was no family history, no personal history, no collateral history, the formulation was poor and the record stated “see Kardex” for medication information. In two other files of residents identified as having suicidal ideation, suicidal risk was not adequately elucidated despite the risk assessment stating that one resident was of high risk of suicide in their risk assessment. All residents had an initial physical examination.

The individual care plan was not in accordance with Article 15 of the Regulations.

The approved centre was compliant with Article 27 of the Regulation on Maintenance of Records, Articles 7 on Clothing and Article 8 on Personal Property and Possessions.

Breach: 15.3, 15.5 17.1

Part 4 Transfer Process

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

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
X			

Justification for this rating:

The decision to transfer was made by a registered medical practitioner. All relevant documentation accompanied the resident on transfer. The approved centre was compliant with Article 18 of the Regulations on Transfer.

Part 5 Discharge Process

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

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
X			

Justification for this rating:

The standard of discharge procedure was good. There was evidence that there was discharge planning in conjunction with the resident. Follow-up for the resident was clearly outlined. A discharge summary was completed and a copy sent to the resident's general practitioner.

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

Description: There was no resident with intellectual disability and mental illness in the approved centre at the time of inspection.

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

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
X			

Justification for this rating:

Training in intellectual disability and mental illness was ongoing. There was no resident with intellectual disability in the approved centre at the time of inspection. There was a policy on intellectual disability and mental illness.

2.5 EVIDENCE OF COMPLIANCE WITH SECTIONS 60/61 MENTAL HEALTH ACT 2001 (MEDICATION)

SECTION 60 – ADMINISTRATION OF MEDICINE

Description: One detained patient had been in-patient and in receipt of medication for a period in excess of three months.

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

Justification for this rating:

The patient had provided written consent for the administration of medication.

SECTION 61 – TREATMENT OF CHILDREN WITH SECTION 25 MENTAL HEALTH ACT 2001 ORDER IN FORCE

Description: No child had been detained in the DOP in 2013 up to the time of inspection and Section 61 did not apply.

SECTION THREE: OTHER ASPECTS OF THE APPROVED CENTRE

SERVICE USER INTERVIEWS

Inspectors greeted residents during the course of the inspection.

ADVOCACY

Service user voice was well developed in the approved centre. There was strong National Service User Executive input to service development.

An independent advocate from the Irish Advocacy Network (IAN) visited the approved centre regularly and provided a written report on residents views. This 2013 report stated that some service users reported that: “the food is good and they can plenty of choice at mealtimes; having a room of their own in sub-acute unit and having access to the garden is of value to some service users in sub –acute unit; some services users reported that they received excellent treatment in D.O.P.”.

The IAN report highlighted areas to be improved: “boredom on acute and sub-acute units in D.O.P., Kilkenny, very little to do if you have no interest in relaxation classes; staff shortages have a negative impact on the service user as staff have less time to talk to service users; public phones in acute and sub-acute units in D.O.P. Kilkenny not working which results in service users requiring staff assistance if they want to use the phone, this limits service user’s independence; service users reported that they required better support when trying to find suitable accommodation; more one to one time with your psychiatrist; clarity regarding care planning, its purpose, process etc.; being referred to Rehab is regarded as a negative outcome by some service users they reported that you get referred to Rehab if you have no hope of recovery; not feeling safe in acute unit, D.O.P., Kilkenny”.

OVERALL CONCLUSIONS

The 44-bed DOP was a busy acute facility providing care and treatment for residents from eight sector teams, two psychiatry of old age teams and two rehabilitation teams. A daily morning meeting of medical and nursing staff had been introduced to enhance timely communication about the unit and the status of residents. Multidisciplinary teams were not adequately staffed with health and social care professionals. The culture in the approved centre was recovery orientated with a strong community focus. The quality of the individual care plans had slipped and in 2013 the approved centre was not fully compliant in this regard.

Service user voice was well developed in the service and there was good representation on service development committees. The DOP had an excellent resource room which gave residents and families ready access to information and to community groups.

The unit was in need of redecorating as parts had become shabby and the supply and quality of seating was particularly poor. Two ligature points remained in the approved centre on the day of inspection despite previous fatal incidents associated with them. On inquiry by the Inspectorate, management subsequently advised that an audit had been completed and ligature points had been removed.

The admission assessments done by the non consultant hospital doctors were not of a good standard. A number of key areas of assessment were missing and documentation was poor. This was the second year in a row where admission procedures and recording were not of a good standard.

RECOMMENDATIONS 2013

1. Training should take place with non consultant hospital doctors in psychiatric assessment and documentation during the admission process.

2. Individual care plans must meet the standard specified in Article 15.

3. Multidisciplinary teams should be adequately staffed with health and social care professionals.

4. Privacy blinds must be installed as planned in the bedroom doors.

5. Documentation in respect of physical restraint must meet the standard of the Code of Practice.