Report of the Inspector of Mental Health Services 2010

EXECUTIVE CATCHMENT AREA	Independent Sector
HSE AREA	Independent Sector
CATCHMENT AREA	Independent Sector
MENTAL HEALTH SERVICE	Independent Sector
APPROVED CENTRE	St. John of God Hospital Limited
NUMBER OF WARDS	8
NAMES OF UNITS OR WARDS INSPECTED	Ginesa Ward Carraig Dubh Ward St. Peter's Ward St. Paul's Ward
TOTAL NUMBER OF BEDS	183
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	10 August 2010

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

INTRODUCTION

In 2010, the Inspectorate paid particular attention to Articles 15 to 22 and 26 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 and all areas of non-compliance with the Regulations in 2009 and any other Article where applicable. 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 2009. Information was gathered from self-assessments, service user interviews, staff interviews and photographic evidence collected on the day of the inspection.

DESCRIPTION

St. John of God Hospital was a large Independent hospital situated in extensive grounds in the suburbs of south Dublin. It provided acute care for residents ranging from adolescence to psychiatry of old age. It also provided a range of specialist services including an eating disorders programme, a substance misuse programme, psychosis programme and a specialist adolescent service. In addition to providing private care for residents nationwide, St. John of God Hospital provided a catchment area in-patient service for the Cluain Mhuire service.

DETAILS OF WARDS IN THE APPROVED CENTRE

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
St. Peter's	18	18	General Adult
St. Paul's	34	27	General Adult
St. Joseph's	28	27	General Adult
St. Camillus's	27	25	General Adult
St. Brigid's	24	24	General Adult
Carrickfergus	24	23	Psychiatry of Old Age
Carraig Dubh	16	16	Psychiatry of Old Age
Ginesa	12	6	Child and Adolescent

QUALITY INITIATIVES

- The approved centre had developed risk management procedures including health and safety procedures.
- A Risk Officer had been appointed to the approved centre.
- A Clinical Risk Management committee had been established which reviewed clinical incidents, complaints and 'near misses'.
- Two projects on PDR (Personal Development Review) had begun which was intended to enhance the professional development of nursing staff.
- A number of audits had been carried out, including audit on medication, items of care and prescribing of as required (PRN) medication, and young people's experiences of their stay on Ginesa ward.
- In Ginesa ward, a Pet Therapy programme was commencing.
- In Ginesa ward, an air conditioning unit had been installed in a room used for relaxation.

PROGRESS ON RECOMMENDATIONS IN THE 2009 APPROVED CENTRE REPORT

1. Individual care plans must be introduced for each resident. (This was a recommendation in both 2008 and 2007).

Outcome: Individual care plans as described in the Regulations had not been introduced.

2. The approved centre was required to provide information for residents in relation to diagnosis and medication. (This was a recommendation in 2008). Administration support must be sufficient to ensure clinical information was filed promptly in clinical files.

Outcome: The approved centre had developed a system for staff to access information on medication and diagnosis through the hospital intranet. This information was available to residents upon request.

3. Seclusion details must be fully recorded in the clinical files. (This was a recommendation in 2008).

Outcome: An audit had been carried out on this recommendation. The Seclusion register and clinical files on the wards regarding seclusion were examined by the Inspectorate on the day of Inspection and had been fully completed.

4. Physical restraint details must be fully recorded in the clinical files. (This was a recommendation in 2008).

Outcome: An audit had been carried out on this recommendation. The Clinical Practice Form Book and clinical files on the wards regarding physical restraint were examined by the Inspectorate on the day of Inspection and had been fully completed.

5. The composition of the management team should be reviewed in line with *A Vision for Change*. (This was a recommendation in both 2008 and 2007).

Outcome: The management team had been altered to include Heads of Clinical Disciplines.

6. The system for identification of residents on St. Peter's unit should be reviewed to ensure that it was appropriate for the residents there. (This was a recommendation in 2008).

Outcome: Photographic identification had been introduced throughout the hospital.

7. Staffing of the multidisciplinary teams should include dedicated health and social care professionals in order to facilitate development of expertise in specialist areas.

Outcome: Multidisciplinary teams had a complement of health and social care professionals attached, although these were often shared across teams.

8. The register of residents should be amended to gather all the information specified in Schedule 1 of the Regulations.

Outcome: PPS numbers were collected from all residents where it was known to the resident.

9. The development of the intranet system should include a facility for alerting the approved centre when policies were due for review. The service was required to review policies at least every three years or as specified by the Inspectorate or the Rules and Codes of Practice.

Outcome: This had been achieved.

10. The risk management policy must specifically address the precautions in place to control risk of suicide and self-harm and should include reference to the admissions policy.

Outcome: Issues relating to risk management were now incorporated in the admission policy.

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

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

Article 4: Identification of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 5: Food and Nutrition

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 6 (1-2): Food Safety

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 7: Clothing

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 8: Residents' Personal Property and Possessions

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 9: Recreational Activities

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 10: Religion

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 11 (1-6): Visits

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 12 (1-4): Communication

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

Confidential incoming post intended for one resident had not been forwarded to the resident and was filed in the back of their clinical file unopened. Outgoing post for another resident had not been posted by staff and was filed in the back of their clinical file. There was no documentation in the clinical file to explain this. This issue was brought to the attention of the approved centre by the Inspectorate and was immediately addressed.

Article 13: Searches

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*	X	
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

The approved centre had a policy on conducting searches. The clinical file of one resident on St. Paul's ward whose property was searched had given consent to the search and was recorded in their clinical file.

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

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 15: Individual Care Plan

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*	X	
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		X

Justification for this rating:

The approved centre was not using individual care plans for residents in the adult section of the hospital as described in the Regulations. The 'Integrated Care and Treatment Plan' in operation in the approved centre was not multidisciplinary in nature and did not identify an individual's needs, goals, interventions and disciplines responsible for carrying out the intervention. There was no facility to provide the resident with a copy of their individual care plan. There was evidence that some multidisciplinary team meetings were held, as seen in the clinical files of some residents.

Residents in the adolescent ward, Ginesa, had individual care plans which were compliant with the Regulations. All of the young people who spoke to the Inspectorate were aware of their individual care plan and had opportunities to contribute to it.

Breach: 15

Article 16: Therapeutic Services and Programmes

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*	X	X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

There were a number of activities available for residents in the approved centre. The occupational therapy department provided a range of therapies and there was also evidence that residents were seen by members of the social work and psychology departments. Specific services were provided for residents in the eating disorder and substance misuse programmes.

In the absence of individual care plans, it was not possible to provide therapeutic services and programmes which were linked to individual care plans. In Ginesa ward, therapeutic services and programmes were linked to the individual care plan.

Breach: 16 (1)

Article 17: Children's Education

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*	X	

Justification for this rating:

Ginesa had a full-time teacher and a full-time special needs assistant.

Article 18: Transfer of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

The approved centre had an up-to-date policy on the transfer of residents. There were procedures for the transfer of residents within the hospital and for transfer to external hospitals.

Article 19 (1-2): General Health

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

The clinical files of a number of residents who had been resident for a period in excess of six months were examined. Physical health checks had been carried out on these residents within the previous six months.

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

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*	X	X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

On admission, residents were given an information leaflet on the hospital and housekeeping arrangements. There were information leaflets on each individual programme. Information on medication and diagnosis was available upon request from the resident, but was not provided routinely. Information on Advocacy Services was displayed throughout the wards. There was an up-to-date policy on the provision of information.

On Ginesa ward there was a variety of information provided for the young people including information on diagnoses.

Breach: 20 (1) (c) (e)

Article 21: Privacy

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

The accommodation in the approved centre was of a very high standard and all shared bedrooms had partition curtains. Residents' privacy was respected by staff.

Article 22: Premises

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

The overall standard of fittings and furnishings was of a very high standard. The building was well maintained. In Carraig Dubh ward one bathroom had been out of commission for over a year, and the one remaining bathroom did not have a shower. This was unsatisfactory for a ward population of 16 elderly residents.

Breach: 22 (1) (c)

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

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 24 (1-2): Health and Safety

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 25: Use of Closed Circuit Television (CCTV)

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 26: Staffing

WARD OR UNIT	STAFF TYPE	DAY	NIGHT
Carraig Dubh	CNM 1/ CNM2	1	0
	Staff Nurse	4 (0800h-1400h)	2 to 3
		3 (1400h-2000h)	
	Household Staff	3	0
St. Peter's Ward	Nurse	6 (0800h-1400h)	3
		5 (1400h-2000h)	
St. Paul's Ward	Nurse	5 (0800h-1400h)	2
		4 (1400h-2000h)	
Ginesa Ward	Nurse	4 (0800h-1400h)	3 (2000h-2300h)
		3 (1400h-2000h)	2 (2300h-0800h)
	Household	1	0

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

The approved centre had a full complement of nursing staff. Multidisciplinary teams had a complement of health and social care professionals attached, although these were often shared across teams. In addition to the core multidisciplinary team, Ginesa ward provided a wide variety of skill mix, including sessional dietician, drama therapist, art therapist and a well-being therapist.

Article 27: Maintenance of Records

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*	X	X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

Most clinical files were in good condition. In two clinical files examined, some records, test results and personal mail were packed into the back of the resident's clinical files. This practice led to some information not being easily retrievable by the appropriate health professional. In some of the files the clinical notes were detached from the file. The approved centre provided a copy of the most recent Food Safety Inspection report.

Breach: 27 (1)

Article 28: Register of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*	X	
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

All information as specified in Schedule 1 of the Regulations was available in the Register were this information was known to the resident.

Article 29: Operating policies and procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*	X	X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

A number of policies were not reviewed within the appropriate timescale. This was highlighted to the approved centre on the day on Inspection.

Breach: 29

Article 30: Mental Health Tribunals

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 31: Complaint Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 32: Risk Management Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*		
Substantial compliance	*Evidence of substantial compliance but improvement needed.*	X	X
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Justification for this rating:

The approved centre had developed an admission policy and procedures which incorporated clinical risk assessment of residents. A risk officer had been appointed. Other policies also incorporated risk assessment and management, but the issue of risk management policy was not stated in one comprehensive written risk management policy. Incidents were recorded and provided to the Mental Health Commission.

Breach: 32 (1)

Article 33: Insurance

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

Article 34: Certificate of Registration

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010
Fully compliant	*Evidence of full compliance with this Regulation.*	X	X
Substantial compliance	*Evidence of substantial compliance but improvement needed.*		
Compliance initiated	*An attempt has been made to achieve compliance but significant progress is still needed.*		
Not compliant	*Service is unable to demonstrate structures or processes to be compliant with this Regulation.*		

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

SECLUSION

Use: Seclusion was used on St. Peter's Ward, which had a suite of two seclusion rooms, an observation area and bathroom facilities. These facilities were of a high standard. At the time of Inspection there had been 66 episodes of seclusion on 17 residents in 2010.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
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 approved centre had introduced a seclusion checklist of all the details required but this checklist was not being fully completed by staff. In all clinical files reviewed on the day of Inspection there was no record in the clinical files that a review by members of the multidisciplinary team involved in the resident's care and treatment had taken place after the episode of seclusion.

Breach: 10.3

ECT (DETAINED PATIENTS)

Use: ECT was administered twice per week. One detained patient was receiving ECT at the time of the Inspection.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	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:

The clinical file of the patient who was receiving ECT was examined. As consent from the patient was not obtained, a review by a second consultant psychiatrist was carried out and the relevant Form 16 was completed. There was evidence in the clinical file that the patient had received information on ECT and that the next-of-kin had also been given information. Prior to ECT being carried out, a physical examination was carried out. The ECT suite was well equipped and was of a very high standard. There was a designated consultant psychiatrist for ECT and the approved centre had two trained ECT nurses.

MECHANICAL RESTRAINT

Use: Mechanical restraint was not used in the approved centre and there was a policy to this effect.

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

PHYSICAL RESTRAINT

Use: Physical restraint was not used in Carraig Dubh ward and no Physical Restraint Clinical Practice Form book was kept on the ward. The Clinical Practice Form kook was reviewed on St. Peter's ward. At the time of Inspection there had been 78 episodes of physical restraint on 22 residents in 2010. Physical restraint had not been used in Ginesa ward in 2010.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
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:

The Clinical Practice Form book for Physical Restraint was examined on both St. Peter's and St. Paul's ward. Although St. Paul's ward did use physical restraint, all entries in the Clinical Practice Form book were recorded in St. Peter's Ward Clinical Practice Form book. The Clinical Practice Form book on St. Paul's Ward was empty.

The completed Clinical Practice Forms on both St. Peter's and St. Paul's Wards were not placed in the resident's clinical file after each episode of physical restraint.

The approved centre had introduced a physical restraint checklist of all the details required but this checklist was not being fully completed by staff.

In all clinical files examined on the day of Inspection there was no record in the clinical files that a review by members of the multidisciplinary team involved in the resident's care and treatment had taken place after the episode of physical restraint.

Breach: 8.3, 9.3

ADMISSION OF CHILDREN

Description: All children and adolescents were admitted to Ginesa Ward.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
2	**Admission**	X			
3	**Treatment**	X			
4	**Leave provisions**	X			

Justification for this rating:

In the clinical files examined, consent for admission and treatment had been obtained. Initial assessments had been completed including risk assessments. Interim individual care plans had been drawn up until the first team meeting at which time a full multidisciplinary care plan was devised. Leave arrangements were clearly documented.

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

Description: There were two deaths of residents in the approved centre in 2010.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
2	**Notification of deaths**	**X**			
3	**Incident reporting**		**X**		
4	**Clinical governance**		**X**		

Justification for this rating:

Deaths were notified to the Mental Health Commission. There was a system in place for reporting incidents. The service did not have a comprehensive risk management policy. The approved centre was not in full compliance with Article 32 of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

Breach: 3.1, 3.2, 4.1

ECT FOR VOLUNTARY PATIENTS

Use: One resident was receiving ECT at the time of Inspection.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	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 clinical file of one resident who was receiving ECT was examined. There was evidence that the resident had given written consent for each treatment. A physical examination had been carried out prior to the administration of ECT. A record of the administration was kept. The ECT suite had a separate waiting room, treatment room and recovery room. There were two designated consultant psychiatrists and two trained ECT nurses.

ADMISSION, TRANSFER AND DISCHARGE

Description: St. John of God Hospital provided acute care for residents and as such, had frequent admissions. Transfers to other hospitals were not uncommon.

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	COMPLIANCE INITIATED	NOT COMPLIANT
	X		

Justification for this rating:

The approved centre had policies on admission, transfer and discharge. These policies incorporated policies on assisted admission, self-referrals, discharge against medical advice and discharge of homeless and elderly residents, among others. Procedures for the admission and discharge process identified the role of staff members in the process. Although risk management procedures were in place, the approved centre did not have a comprehensive policy on risk management and was not compliant with Article 32 of the Regulations.

Breach: 7.1

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	COMPLIANCE INITIATED	NOT COMPLIANT
	X		

Justification for this rating:

The admission procedures were clearly described and there were procedures in place for assessment, risk management after admission and for giving information to residents. All teams had multidisciplinary involvement but individual care plans were not in operation in the approved centre. The approved centre operated a key-worker system. The approved centre was not fully complaint with Article 20 related to the provision of information to residents, or Article 27 relating to maintenance of records.

Breach: 16.3.c 17, 22.6

Part 4 Transfer Process

The following aspects were considered: 25. Transfer criteria, 26. decision to transfer, 27. assessment before transfer, 28. resident involvement, 29. multi-disciplinary 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	COMPLIANCE INITIATED	NOT COMPLIANT
X			

Justification for this rating:

The decision to transfer was made by the medical staff in conjunction with the multidisciplinary team. Residents were accompanied by a staff member and written documentation was sent with the resident. The approved centre had an intra-hospital transfer form for transfers within the hospital. A policy on transfers was in place.

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	COMPLIANCE INITIATED	NOT COMPLIANT
	X		

Justification for this rating:

No clinical files of residents who had been discharged were examined. The Inspectorate examined a number of clinical files of residents whose discharge was being planned. There was evidence of follow-up arrangements and contact with relevant agencies and professionals. The approved centre was not fully complaint with individual care plans.

Breach: 34.1

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

Description: There were no residents in the approved centre with an intellectual disability and mental illness up to 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	COMPLIANCE INITIATED	NOT COMPLIANT
		X	

Justification for this rating:

The approved centre was in the process of developing policies and protocols for compliance with this Code of Practice.

Breach: 5, 6, 7, 8, 9, 10, 11, 12, and 13

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

SECTION 60 – ADMINISTRATION OF MEDICINE

Description: Six clinical files were examined on the day of Inspection.

SECTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	COMPLIANCE INITIATED	NOT COMPLIANT
Section 60 (a)	X			
Section 60 (b)(i)	X			
Section 60 (b)(ii)	X			

Justification for this rating:

In the files examined by the Inspectorate, the administration of medication to patients for a period of time in excess of three months was compliant with the Rules.

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

Description: There were no children admitted under Section 25.

SECTION THREE: OTHER ASPECTS OF THE APPROVED CENTRE

SERVICE USER INTERVIEWS

Although all residents were greeted informally by the Inspectorate on the day of Inspection, no adult residents requested to speak formally with the Inspectorate. All of the young people who spoke to the Inspectorate were generally satisfied with their care and treatment. They described their environment as well kept and comfortable. They found staff approachable and supportive. They raised an issue that they said they had brought up before with the catering department, that although they were provided with a choice of meals they often did not know what they were choosing as the name of the dish did not indicate the foods used.

MEDICATION

The medication sheets were in booklet format and were in the most part legible. PRN (as required) medication was separate from regular medication. In some cases the indications for PRN medication was documented which was excellent. This should be done in all PRN prescriptions.

MEDICATION ACUTE

NUMBER OF PRESCRIPTIONS:	157
Number on benzodiazepines	72 (46%)
Number on more than one benzodiazepine	12 (8%)
Number on regular benzodiazepines	38 (24%)
Number on PRN benzodiazepines	51 (32%)
Number on hypnotics	59 (38%)
Number on Non benzodiazepine hypnotics	45 (29%)
Number on antipsychotic medication	90 (57%)
Number on high dose antipsychotic medication	0
Number on more than one antipsychotic medication	10 (6%)
Number on PRN antipsychotic medication	25 (16%)

Number on antidepressant medication	**69 (44%)**
Number on more than one antidepressant	**5 (3%)**
Number on antiepileptic medication	**17 (11%)**
Number on Lithium	**22 (14%)**

OVERALL CONCLUSIONS

St. John of God Hospital was located in spacious ground in south Dublin and provided acute in-patient adolescent and adult psychiatric services as well as services for Psychiatry of Old Age. The approved centre was clean and well maintained and the seclusion and ECT facilities were of a high standard. It was evident that there were positive working relationships between staff and residents within the service.

Apart from Ginesa Ward, the service was not using individual care plans for residents in the adult section of the hospital as described in the Regulations. The 'Integrated Care and Treatment Plan' in operation in the approved centre was not multidisciplinary in nature and did not identify an individual's needs, goals, interventions and disciplines responsible for carrying out the intervention. There was no facility to provide the resident with a copy of their individual care plan.

RECOMMENDATIONS 2010

1. Each resident must have an individual care plan that meets the requirements of the Regulations.

2. All therapeutic services and programmes that are provided must be in accordance with the individual care plan.

3. The approved centre should develop and implement policies regarding how staff works with people with an intellectual disability and mental illness.

4. Post coming to or going from residents should not be blocked unless this was clinically indicated and documented.

5. The ongoing work relating to devising a comprehensive risk management policy should progress.

6. The menu should include a description of the main foods used in each dish, if this was not evident from the name of the dish.

7. The bathroom which has been out of commission in Carraig Dubh ward for over a year should be commissioned immediately.