Report of the Inspector of Mental Health Services 2008

HSE AREA	HSE South
CATCHMENT	South Lee
MENTAL HEALTH SERVICE	South Lee
APPROVED CENTRE	South Lee Adult Mental Health Unit (SLAMHU), Cork University Hospital
NUMBER OF UNITS OR WARDS	1
UNITS OR WARDS INSPECTED	South Lee Adult Mental Health Unit
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	46
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	18 June 2008

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

INTRODUCTION

In 2008, there was a focus on continuous quality improvement across the Mental Health Service. The Inspectorate was keen to highlight improvements and initiatives carried out in the past year and track progress on the implementation of recommendations made in 2007. Information was gathered from service user questionnaires, staff interviews and photographic evidence collected on the day of the inspection.

The Inspectorate met with a number of residents, a consultant psychiatrist, the director of nursing, a number of assistant directors of nursing, the CNM3 and CNM2 on the unit, representatives of clinical psychology, occupational therapy and social work. A feedback meeting was facilitated following the inspection.

DESCRIPTION

The South Lee Adult Mental Health Unit (SLAMHU) was located in Cork University Hospital. The unit was spread over two floors and there was limited space for offices, interview rooms and day areas for residents. There was no access to the second floor for people with limited mobility.

A number of older residents with dementia were difficult to place, resulting in beds being blocked for acute admissions and their high dependency needs limited the availability of nursing staff to other residents. Up to six sector teams and the psychiatry of later life team had admitting rights to the unit.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
SLAMHU	46	46	6 General Adult 1 Psychiatry of Later Life

The service had lost a number of posts that were vacant at the end of 2007, including a clinical psychologist and night superintendent. Of the 2007 development posts, two community mental health nurse posts and a senior clinical psychologist post had been filled. Most of the health and social care professions were shared across

teams and this limited their availability and capacity to deliver services and participate in service developments and affected the quality of care and treatment to residents.

Last year the Inspectorate was informed about plans to re-develop the first floor to include a day room, accessible bathroom (though without lift access) and a high observation area for male patients with two single rooms and nurse's station. Staff expressed concern that if this plan was not sent for tender soon, the funding would be lost. Staff reported that this development would require an additional 5.0 whole-time-equivalent posts and no provision had been made for this.

Staff reported that there had been difficulties in accessing maintenance and participating in hospital-wide initiatives and routine audits, e.g. hygiene audits, because the unit was funded by Primary Community and Continuing Care (PCCC) rather than by the acute hospital budget.

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. A high observation area must be developed.

Outcome: No progress had been made on this recommendation.

2. A full multidisciplinary team in rehabilitation should be appointed.

Outcome: No progress had been made on this recommendation.

3. The vacant posts in occupational therapy must be advertised.

Outcome: An occupational therapist manager was appointed in March 2008. The manager was trying to establish if the other occupational therapy posts vacant last year had been lost following HSE HR circular 01/08.

MDT CARE PLANS 2008

There were no developments since last year. The individual care plan was drawn up by medical and nursing staff at the weekly ward round. Due to insufficient health and social care professionals they did not routinely attend ward rounds.

GOOD PRACTICE DEVELOPMENTS 2008

- An occupational therapist manager had been appointed in March 2008.
- An artist in residence programme had begun on the unit.
- New nursing care plans had been introduced.
- A training DVD on safe alcohol use for patients had been produced for use by staff in Emergency Departments.
- The rate of transfers to Carraig Mór had decreased.

SERVICE USER INTERVIEWS

Four service users spoke to the Inspectorate. They were asked to comment on five key areas: care plans, therapeutic services and programmes, general health, information and privacy. All reported that they knew who their key nurse was. All reported attending the group programme and were happy with the content. They reported that information was provided by nursing staff and the advocate who visited the ward weekly. Each had an individual screen around their bed. No service user interviewed had a copy of their care plan. One person raised the issue of toilets on the ward being blocked from time to time and also the inadequate bathroom facilities for the elderly residents.

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

1. A high observation area should be developed and adequate funding made available to build and staff it.

2. Funding should be made available to appoint a rehabilitation team.

3. Funding should be made available to appoint dedicated core disciplines to all the teams.

4. A service agreement between the acute hospital and the mental health service, under PCCC, should be developed to ensure maintenance, refurbishment and access to hospital wide audits.

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

INTRODUCTION

In 2008, the inspection focused on areas of non-compliance identified in 2007. In addition, the Inspectorate re-inspected compliance with all the articles in part three of the Regulations (15–21 and 26) and the Rules and the Codes of Practice in each approved centre. In 2008, two new codes of practice were issued and compliance with them was inspected. Where conditions were attached, they were inspected in detail. Evidence of compliance was established through three strands:

- Inspection of compliance where there was a breach in 2007. This was cross-referenced with the action plan submitted to the MHC Standards and Quality Assurance Division.
- Written evidence requested prior to the inspection, for example policies.
- Evidence gathered during the course of the inspection from staff, service users, photographic evidence and photocopies.

2.1 EVIDENCE OF COMPLIANCE WITH CONDITIONS ATTACHED TO REGISTRATION

As no conditions were attached, this was not applicable.

2.2 EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d) ON 18 JUNE 2008

Article 15: Individual Care Plan

The team continued to operate a pre-ward round sheet incorporating an individual care plan. Before the ward round, the key nurse met with the resident to review the goals. Attendance at the ward round was mainly by medical and nursing staff, due to very limited access to health and social care professionals. Sections relating to attendance at the review were often left blank. Care plans were completed weekly by the NCHD. The service reported that the care plan was being revised and an agreed one would be in place by the end of September 2008 and would be audited within six months and regularly thereafter.

Breach: A number of files were reviewed on the day of the inspection and the care plans were incomplete with no clear goals recorded [Article 15]. Photographic evidence was taken.

Compliant: No

Article 16: Therapeutic Services and Programmes

A CNM1 facilitated the therapy programme and met every Monday with the CNM2s on the unit to plan the programme and review the residents. An artist in residence provided group and individual work for residents. An occupational therapist manager was in post and there was a need for a unit-based occupational therapy programme. Therapeutic services and programmes must be linked to the individual care plan. The service reported that a member of the day therapy team would commence attending ward rounds to enhance the link between care plans and the unit-based programme.

Breach: A range of therapeutic services and programmes were not provided as there was limited availability of health and social care professionals [Article 16 (1)].

Compliant: No

Article 17: Children's Education

There had been two children admitted on the male side since the last inspection. Both were over 16 and were short admissions. Education was assessed as not being an issue at the time of admission.

Compliant: Yes

Article 18: Transfer of Residents

The unit had a local policy relating to the transfer of residents to Carraig Mór. Residents who required transfer to other approved centres were accompanied by nursing staff and their relevant files accompanied them. The NCHD provided a referral letter for residents requiring transfer to a general hospital.

Compliant: Yes

Article 19 (1-2): General Health

The clinical files examined showed evidence that residents had regular general health reviews.

Compliant: Yes

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

An information meeting was facilitated each Monday for new admissions. It was reported that verbal information was given to the resident regarding their diagnosis and written information could be downloaded from the Internet. The Irish Advocacy Network (IAN) visited the unit every week and a number of voluntary agencies visited regularly. Notices about local services and voluntary organisations were on display throughout the ward. A South Lee Mental Health Services booklet was in place. A local policy was in place that met the requirements of this Article. Following inspection, the service reported that information leaflets in relation to diagnosis were being sourced and would be available from September 2008.

Breach: Written information on diagnosis was not routinely provided [Article 20 (1)(c)].

Compliant: No

Article 21: Privacy

The unit had a number of single rooms. These rooms were on the ground floor, which was the sleeping area for women. Male residents often had to be accommodated in these single rooms if they could not manage the stairs. This often reduced the female bed numbers. All residents had a curtain around their bed area in the dormitories.

Compliant: Yes

Article 22: Premises

Staff reported that there were less cleaning staff on the unit than in previous years. The same cleaning staff have to clean the unit and serve food. It was suggested that one more cleaning staff would make a considerable difference. The unit was however clean on the day of inspection. The unit was in need of redecoration and the toilets and bathrooms needed upgrading [Article 22 (1)(a)].

The unit was well lit, heated and ventilated [Article 22 (1)(b)] .

There was not a programme of routine maintenance. Maintenance was provided from the acute general hospital and it was reported that the unit was not prioritised as it was part of the PCCC [Article 22 (1)(c)].

The furniture was suitable. If special seats were required for the elderly residents it was reported as being difficult to acquire these [Article 22 (2)].

The day areas and female bedroom and bathroom areas were located on the ground floor. The male bedroom areas were upstairs. There was no lift access to the first floor. This resulted in elderly male residents been nursed on the ground floor. Staff reported a number of practical problems when nursing elderly residents. On the day of inspection there were ten residents over the age of 65. The bathing areas needed upgrading and the unit required redecoration [Article 22 (3)].

There were poor facilities for people with a physical disability.

Following the inspection, the service reported that the maintenance department will be invited to the next environmental audit due within the next six month, however funding would be required to implement the resulting maintenance plan, the unit is due for repainting within the next three months, plans were in place for upgrading of some bathroom and toilet areas and renovations to the unit have been agreed and put out to tender.

Breach: Article 22 (1)(a), Article 22 (1)(c), Article 22 (3).

Compliant: No

Article 26: Staffing

Staff were recruited through the HSE policies.

The unit did not have core nursing staff, although a significant proportion of the staff had worked on the unit for over a year, some much longer. Health and social care staff were shared across teams, which depleted the attendance at team reviews and hindered the development of MDT care plans. The unit did not have an adequate staff skill mix to meet the assessed needs of the residents.

The service reported that the requirement for appropriate skill mix has been advocated at area management level but lack of funding was a barrier.

Breach: Article 26 (2)

Compliant: No

Article 32: Risk Management Procedures

A system for recording incidents was in place. Incidents were discussed every four to six months at the risk management review group involving the clinical director, director of nursing and ward staff. Staff reported that the multidisciplinary risk management review group identified in the local risk policy was not yet in place, which would include administration, occupational therapy, clinical psychology and social work staff. The review of incidents had led to a number of specific audits being carried out by the CNM3 and related developments in practice e.g. absence without leave policy and suicide. The service reported that the Risk Management policy would be reviewed

Breach: The requirements of the local policy were not being met[Article 32 (1)]. The policy did not include the requirements of Section 4 of the Code of Practice on Notification of Deaths and Incident Reporting [Article 32 (3)].

Compliant: No

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

SECLUSION

There were no seclusion facilities on the unit. Staff reported that seclusion was not used. The service submitted written confirmation that seclusion was not used.

Compliant: Yes

ECT

On the day of the inspection, there were no detained patients in receipt of ECT and no detained patients had received ECT. The service submitted written confirmation that no detained patient had received ECT since January 2008.

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Rules for the Use of ECT.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Consent**	Not applicable
3	**Information**	Compliant
4	**Absence of consent**	Not applicable
5	**Prescription of ECT**	Not applicable
6	**Patient assessment**	Not applicable
7	**Anaesthesia**	Compliant
8	**Administration of ECT**	Not applicable
9	**ECT Suite**	Compliant
10	**Materials and equipment**	Compliant
11	**Staffing**	Compliant
12	**Documentation**	Not applicable
13	**ECT during pregnancy**	Not applicable

Compliant: Yes

MECHANICAL RESTRAINT

Staff reported that no form of mechanical restraint was in use. The service submitted a written statement confirming that mechanical restraint was not used.

SECTION	DESCRIPTION	COMPLIANCE REPORT
21	**Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour**	This was not in use on the day of the inspection.

Compliant: Not applicable

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

PHYSICAL RESTRAINT

The physical restraint register was reviewed. One file was cross referenced with the code of practice. The unit had a policy on physical restraint.

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Code of Practice for the Use of Physical Restraint.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Orders**	The file showed evidence that the orders had been written as prescribed in the code. The staff reported that the family were informed verbally. It was not recorded in the notes [Article 2.10].
3	**Resident dignity and safety**	Compliant
4	**Ending physical restraint**	Compliant
5	**Recording use of physical restraint**	Compliant
6	**Clinical governance**	Non-compliant. The policy must be reviewed at least annually.
7	**Staff training**	Non compliant Regular or refresher courses for staff in physical restraint were not provided [Section 7.1] and therefore the staff training record was not up to date [Section 7. 2].
8	**Child residents**	Not applicable

Breach: Section 2.10, Section 6.1(d), Section 7.1, Section 7.2

Compliant: No

ADMISSION OF CHILDREN

Staff reported that two children had been admitted to the approved centre since the last inspection. However, the Mental Health Commission was notified of only one admission from September 2007 to June 2008. There was no child admitted on the day of inspection and no files were reviewed.

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Code of Practice for the Admission of Children under the MHA 2001.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Admission**	Non-compliant. The service did not have a policy requiring each child to be individually risk assessed [Section 2.5(i)] or policies for family liaison, parental consent and confidentiality [Section 2.5(l)]. Clarification required in relation to documentation in clinical file [Section 2.5(h)] and consent [Section 2.7]. The Commission was not notified of one admission [Section 2.5(m)].
3	**Treatment**	Clarification required in relation to consent [Section 3.2].
4	**Leave provisions**	Not applicable as admissions were voluntary.

Breach: Section 2.5(i), Section 2.5(l), Section 2.5(m)

Compliant: No

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Code of Practice for the Notification of Deaths and Incident Reporting.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Notification of deaths**	Compliant
3	**Incident reporting**	Compliant
4	**Clinical governance**	Non-compliance. Sections 3.1 and 3.2 of the local risk policy were not in place [Section 4.2]. The risk management policy did not include requirements of [Section 4.3].

Breach: Section 4.2 and Section 4.3

Compliant: No

ECT FOR VOLUNTARY PATIENTS

No voluntary patient was in receipt of ECT on the ward on the day of the inspection. The service confirmed that no voluntary patient had received ECT since January 2008.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Consent**	Not applicable
3	**Information**	Compliant
4	**Prescription of ECT**	Not applicable
5	**Assessment of voluntary patient**	Not applicable
6	**Anaesthesia**	Not applicable
7	**Administration of ECT**	Not applicable
8	**ECT Suite**	Compliant
9	**Materials and equipment**	Compliant
10	**Staffing**	Compliant
11	**Documentation**	Not applicable
12	**ECT during pregnancy**	Not applicable

Compliant: Yes

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

Section 61 was not applicable. In relation to Section 60, a number of files were reviewed and were in order.

Compliant: Yes