Report of the Inspector of Mental Health Services 2008

HSE AREA	HSE Dublin North East
CATCHMENT	North West Dublin
MENTAL HEALTH SERVICE	North West Dublin
APPROVED CENTRE	St. Brendan's Hospital
NUMBER OF UNITS OR WARDS	5
UNITS OR WARDS INSPECTED	Unit O Unit 8A Unit 8B Unit 3A Unit 3B
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	84
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	23 October 2008

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

INTRODUCTION

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

DESCRIPTION

St. Brendan's Hospital was situated in Grangegorman on the north side of Dublin city. Many parts of the old hospital have been closed down and were no longer used as in-patient facilities. The remaining units were all housed in old buildings and were configured as follows:

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Unit O	12	11	Consultant-led team
Unit 8A	12	11	Consultant-led team
Unit 8B	12	11	Consultant-led team
Unit 3B	27	25	Sector teams Rehabilation team
Unit 3A	21	21	Sector teams Rehabilation team

Unit O was a low secure female admission ward on the ground floor.It had 11 residents on the day of inspection, seven of whom were detained. The mix of residents on the ward was of particular concern to staff, residents and the Inspectorate. The needs of people who have learning disability, personality disorder and serious mental illness, including self-harming behaviour were not easily managed when all were together in a confined space.

Unit 8A was a low secure male admission ward on the ground floor that had 11 residents, four of whom were detained. The unit was under the care of one multidisciplinary team and a 0.5 whole-time-equivalent (WTE) occupational therapist and a 0.5 WTE staff grade occupational therapist were assigned to this unit. There were ongoing problems transferring residents back to the services they had been transferred from, once their needs had been met in a secure ward, despite agreed admission protocols. The consequence of this was that residents stayed longer in the unit, increased pressure on beds and at times transfer to unit 8B. The residents had complex forensic needs but no specialist forensic service or resource was available to them. Response times to maintenance issues continued to be slow and the long awaited refurbishment on the seclusion area to include the en-suite facility was almost complete.

Unit 8B was a low secure male continuing care ward situated on the first floor above unit 8A that had 11 residents on the day of inspection. There was a significant lack of provision of therapeutic activities on the unit, only 4 of the 11 residents attended occupational therapy off the unit. The low turnover of beds on unit 8A had contributed to the increase in numbers on unit 8B which sometimes took admissions. The seclusion room on the unit was decommissioned. The residents were under the care of one multidisciplinary team. There was a 0.5 Senior Occupational Therapist and a 0.5 staff grade Occupational Therapist assigned to the unit. Staff reported that maintenance continued to be a problem on this unit.

Units 3A and Unit 3B continued to provide an acute admission service to two sectors and continuing care to a number of long-stay residents transferred to these units following the closure of other units in the hospital. It was hard to justify why people were still admitted to these two units. They were completely unsuitable for an acute admission service and the patient mix was untenable. The unit at Connolly Hospital continued to be occupied by medicine for the elderly and had not been made available to the Mental Health Service. Concerns at the delay of transferring to this new unit have been highlighted on numerous occasions by the North West Dublin Mental Health Service.

This was an old institution unsuited to the needs of a modern therapeutic mental health service. The layout was unsuitable for the needs of the residents and restrictions on funding and planning permission do not allow for the facilities to be adapted to any significant degree to allow for privacy or modernisation. It should be replaced at the earliest opportunity in line with the recommendations of *A Vision for Change*. Acute admissions should cease and should be directed to the new purpose-built in-patient unit at Connolly Hospital.

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. The overall recommendations from 2006 for the service and the special care service remain outstanding and should be acted upon.

Outcome: Multidisciplinary care plans had been introduced on the units. Many residents had a structured day that included going off the unit to attend therapeutic programmes. For others, programmes were provided on the ward. All patient notes were now held in one individual file. There was evidence in the case files for all seclusion periods

2. The opening of the Acute Unit in Connolly Hospital should be completed in full and without further delay.

Outcome: There was no progress with this recommendation.

3. The Willows unit should close immediately and all residents transferred to suitable accommodation.

Outcome: The Willows unit was closed as an in-patient unit.

4. Given that a system of central rostering of nursing staff is used, a system of communicating relevant general and mental health details of a resident's presentation on the units should be implemented.

Outcome: Central rostering continued to be the practice within the hospital. There was evidence of consistency of staffing in the units.

5. MDT care plans should be implemented for all residents.

Outcome: MDT care plans had been implemented on all units.

6. An up-to-date MRSA swab test should be undertaken on the resident in the Willows.

Outcome: This recommendation was resolved.

MDT CARE PLANS 2008

Multidisciplinary individual care planning had been introduced in the approved centre since last year's inspection.

Each resident had a multi-disciplinary individual care plan. The Inspectorate recommended that the care planning process could be enhanced by recording the professional designation of staff members, as well as their names, to demonstrate the level of MDT input at team meetings. MDT team meetings took place weekly and residents were invited to attend if they so wished. There was a social work service available to the Rehab team only and no psychology services were available to residents.

GOOD PRACTICE DEVELOPMENTS 2008

- The Willows unit had closed.
- En-suite facilities are planned for the seclusion area of Unit O.
- Clinical audits were commonplace in the service.
- A standard setting group had been established.
- Clinical supervision training had commenced.
- Clinical discussion groups had been established focussing on legislation and other topical issues

SERVICE USER INTERVIEWS

Unit O: The Inspectors interviewed 5 residents at their request from the special care units. Issues that arose were the 'lack of anyone to talk to', allegation of bullying, inadequate heating on the ward, noise at night time which prevented sleep, worry about having nowhere to go in the event of discharge, boredom, lack of access to reading material, relationships with families, physical health. Some residents were clearly distressed during these interviews. Some were tearful. While one patient had made contact with the Irish Advocacy Network, she complained that the contact was not maintained. Some of the women who spoke to the Inspectorate complained that all the women were accommodated in one unit regardless of their level of distress or their problems and this was particularly difficult for those who were more settled as it was a long-stay unit.

Unit 8A: The Inspectors interviewed one resident. Issues that were raised included access to a social worker for concerns about legal affairs, inadequate heating on the ward and lack of clarity regarding care planning.

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

1. The building which houses the secure units was old and unfit for purpose. It should be closed as soon as possible.

2. Admissions should not be facilitated in Units 3A & 3B and should be facilitated at Connolly Hospital.

3. Funding should be made available to provide core multidisciplinary staffing for the teams. A multidisciplinary focus on care and treatment should be developed immediately.

4. Advocacy services should visit all the units on a regular basis.

5. The approved centre should enforce the agreed protocols for admission and discharge.

6. The forensic needs of residents should be addressed by specialist mental health forensic services.

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

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

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

2.1 EVIDENCE OF COMPLIANCE WITH CONDITIONS ATTACHED TO REGISTRATION

As no conditions were attached, this was not applicable.

2.2 EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d) ON 23 OCTOBER 2008

Article 7: Clothing

Unit 8A: There was one resident recently admitted to the unit in night clothes. This was not recorded in the care plan or progress notes.

Unit O: The use of night clothes was recorded in multidisciplinary care plans.

Breach: The use of night clothes was not part of the care plan

Compliant: No

Article 8: Residents' Personal Property and Possessions

Unit 8A: A policy was in place and a record of residents' personal property and belongings was kept in the back of each clinical file. Money and cigarettes were kept in a locked area on the ward and access to them had to be requested.

Unit 8B: A record of residents' personal property and belongings were kept in their clinical files. An audit checking system was used to track resident's money kept in a safe on the ward.

Unit O: A policy for the service was in place. A record of patients' belongings was being kept in the their files. Money was kept in a locked safe. This system was audited. Residents all had lockers.

Unit 3B: A property list was completed on admission.

Compliant: Yes

Article 9: Recreational Activities

Unit 8A: Residents continued to have little access to recreational activities other than TV, walks or books.

Unit 8B: The unit did not have a sufficient range of appropriate recreational activities to meet the needs of the residents.

Unit O: The unit did not have a sufficient range of recreational activities to meet the needs of residents. During the inspection, patients were observed wandering seemingly aimlessly throughout the rooms and corridors. Others were sitting in the day room and seemed to have nothing to do. Others watched TV.

Unit 3B: A therapy nurse was based on the unit and a range of activities were available.

Breach: The special care units did not have a sufficient range of recreational activities for the residents.

Compliant: No

Article 11 (1-6): Visits

The approved centre had a visitor's policy in place.

Unit O, Unit 8A, Unit 8B and Unit 3B: Visitors were encouraged to visit residents and there were dedicated visitor's rooms on each unit.

Compliant: Yes

Article 15: Individual Care Plan

Unit 8A: An MDT care plan was available and was being utilised with the exception of the social worker and psychologist whose posts were currently vacant.

Unit 8B: MDT care plans were used and residents could attend the MDT meetings.

Unit O: Individual MDT care plans were documented and notes were integrated. There was no psychology input and it was reported that it was unclear as to whether some patients had access to external psychologists, and if so where their interventions were recorded.

Unit 3B: Residents had an MDT care plan. Reviews varied depending on need. The patient mix was untenable.

Compliant: Yes

Article 16: Therapeutic Services and Programmes

Unit 8A: Residents had access to Special Care Therapy and the occupational therapy team visited the unit daily and attended the weekly review. A Positive Health Group and an Orientation Group were facilitated on the unit.

Unit 8B: The occupational therapist visited the ward three to four times weekly as well as attending the weekly reviews. The occupational therapy programmes were linked to individual care plans. The input of the occupational therapist had been revised since the numbers on the unit increased and the service reported that two groups were being provided on a pilot basis to meet the needs of the residents who did not leave the unit. No other therapeutic programmes and services were available.

Unit O: Residents could attend services run by the occupational therapy department. Where residents were unable to leave the ward, individual programmes were developed for them there. However, there was no space available for group programmes. One patient complained that the time given to these programmes was too short. The programmes were linked to the multidisciplinary care plans.

Compliant: Yes

Article 17: Children's Education

One child had been admitted during 2008 for 24 hours.

Compliant: Not applicable

Article 18: Transfer of Residents

Unit O, Unit 8A and Unit 8B: The units had a policy in place for transfers of residents to another approved centre, or to a hospital or other place for treatment. The nursing staff were able to articulate the policy for the external transfer of residents.

Compliant: Yes

Article 19 (1-2): General Health

Unit 8A, Unit O and Unit 3B: There was no documentation to indicate that general health reviews had been carried out at least every six months.

Unit 8B: There was evidence in the clinical notes that six-monthly general health reviews had been carried out.

Breach: Not all residents received a physical every six months.

Compliant: No

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

Unit 8A and Unit 8B: Information booklets were available for residents and visitors. The nursing staff related that information was also given verbally if requested.

Unit O: The approved centre had a policy on the provision of information to residents. Because of security concerns, a list of rules had been developed for display on the ward. It appeared to the Inspectorate that this list was too long and verbose to be of use to the population concerned, many of whom had reading difficulties. A more user-friendly version could be developed.

Compliant: Yes

Article 21: Privacy

Unit 8A and Unit 8B: Privacy on these 12-bed dormitory units was poor. Screens or curtains around each bed had been provided. The ward areas were small and there was no quiet private space available.

Unit O: There were curtains around most of the beds in Unit O. One resident complained that it was hard to sleep at night because of noise in the ward.

Breach: All beds should be partitioned.

Compliant: No

Article 22: Premises

Unit 8A and Unit 8B: Both units were in an unacceptable state of repair and it was apparent that little maintenance had taken place in the last year. The furniture and fittings were old, worn and added to the run-down and neglected appearance of the units. The shower on Unit 8A had not been upgraded and was filthy. There were holes in the bathroom walls and pipes were exposed. The exposed pipe work in shower unit and bathroom on unit 8B had been covered.

Unit O: Overall decor was poor and institutional in nature. There was little furniture in the day room and there was only one bathroom. One resident complained that the building was cold. Facilities in the building should take cognisance of the long period of time some residents spend there.

Unit 3B: The unit was in need of an upgrade. There were maintenance issues that needed attention and the overall decor was poor.

Breach: The premises were unsuitable for a modern mental health service.

Compliant: No

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

The service was compliant with this Article.

Compliant: Yes

Article 26: Staffing

The approved centre had a written policy on the recruitment and selection of staff. The policy stated that all recruitment must follow HSE practice. A system of central rostering of nursing staff was used and staff were frequently moved around the different units. There was some consistency of staffing but overall the central roster system does not facilitate continuity of care. There was access to occupational therapy and social work but not to psychology.

Breach: The skill mix was not sufficient to meet the assessed needs of the residents.

Compliant: No

Article 27: Maintenance of Records

The records on these units were well kept and easy to read.

Compliant: Yes

Article 28: Register of Residents

The service was compliant with this Article.

Compliant: Yes

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

SECLUSION

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

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Orders**	Non-compliant. **Unit 8A:** There was no evidence in the clinical files reviewed about whether or not next of kin were informed about seclusion.
3	**Patient dignity and safety**	Compliant
4	**Monitoring of the patient**	Compliant
5	**Renewal of seclusion orders**	Compliant
6	**Ending seclusion**	Compliant
7	**Facilities**	Non-compliant. **Unit 8A:** The unit had one seclusion room which was located away from the main corridor and the bathroom facilities were some distance away. Work was in progress to build an en-suite facility for the seclusion room. **Unit O:** The unit had one seclusion room planned and work was due to commence in early 2009.
8	**Recording**	Compliant
9	**Clinical governance**	Compliant
10	**Staff training**	Compliant
11	**CCTV**	Compliant
12	**Child patients**	Not applicable

Breach: In Unit 8A there was no evidence in the clinical files reviewed about whether or not next of kin were informed about seclusion [Section (2)(10)].

Facilities in Units 8A and Unit O were not satisfactory.

Compliant: No

ECT

ECT was not provided in this approved centre.

Compliant: Not applicable

MECHANICAL RESTRAINT

The Inspectorate was informed that mechanical restraint was not in use in the approved centre.

Compliant: Not applicable

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

PHYSICAL RESTRAINT

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

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Orders**	Non-compliant. There was no record in the clinical files reviewed of whether or not next of kin had been informed.
3	**Resident dignity and safety**	Compliant
4	**Ending physical restraint**	Compliant
5	**Recording use of physical restraint**	Compliant
6	**Clinical governance**	Compliant
7	**Staff training**	Compliant
8	**Child residents**	Not applicable

Breach: There was no record in the clinical files reviewed of whether or not next of kin had been informed [Section (2)(10)].

Compliant: No

ADMISSION OF CHILDREN

One child was admitted in 2008 for 24 hours. Further information not available.

Compliant: Not inspected.

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**	Compliant

Compliant: Yes

ECT FOR VOLUNTARY PATIENTS

ECT was not provided in this approved centre.

Compliant: Not applicable

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

In the case of one patient in Unit O whose chart was reviewed, the appropriate form had not been properly completed. In Unit 8A, files reviewed were in order in relation to Section 60.

Breach: Appropriate forms not completed.

Compliant: No