Report of the Inspector of Mental Health Services 2008

HSE AREA	HSE South
CATCHMENT	Carlow Kilkenny
MENTAL HEALTH SERVICE	Carlow Kilkenny
APPROVED CENTRE	St Canice's Hospital
NUMBER OF UNITS OR WARDS	2
UNITS OR WARDS INSPECTED	St. Luke's
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	49
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	4 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.

DESCRIPTION

St. Canice's Hospital was an approved centre under the Mental Health Act 2001. There were two wards with a total resident population of 49. All residents were voluntary. St. Gabriel's Ward was under the care of the psychiatry of later life team. St. Luke's Ward was under the care of the rehabilitation consultant, although the majority of the residents were at the later stage of life, a number had returned to the hospital from community residences because of physical reasons.

The residents on St. Luke's Ward were unlikely to fall within a rehabilitation remit and it was difficult to understand why they were the responsibility of the rehabilitation consultant.

Following the inspection, the service reported that a collaborative needs assessment by the rehabilitation and psychiatry of later life teams had commenced and this would determine how these wards will be managed.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
St. Luke's	30	30	Rehabilitation
St. Gabriel's	19	19	Psychiatry of Later Life

Although national mental health policy recommends that all mental hospitals should close, there were no specific plan or timeframe for transfer of residents from St Canice's to other appropriate facilities to facilitate closure. Of the two approved centres in Kilkenny, St. Canice's lags behind the Department of Psychiatry in St Luke's Hospital, in terms of good practice developments and compliance with the Regulations, Rules and Codes of

Practice. The ethos of continuous quality improvement evident in the Department of Psychiatry should be equally applied to the residents in St. Canice's. Following the inspection, the service reported that a number of good practice developments were planned by Autumn 2008.

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. The orders for mechanical restraint must be written in accordance with Part 5 Section 21.4 of the Rules. The orders must be reviewed regularly.

Outcome: Cot sides, mittens, lap belts or buxton chairs were in use on St. Gabriel's and St. Luke's wards. All of the clinical files reviewed contained up-to-date documentation in accordance with Part 5. The use of restraints was reviewed regularly. Detailed daily nursing records were kept of restraints used for enduring self-harm.

2. The issue of responsibility for the maintenance work in St. Gabriel's Ward must be sorted out so that necessary remedial work can be undertaken and the environment for the residents restored. At present, staff are reporting faults and repairs to the maintenance department who are referring these on to the builder. However to date no remedial action has been taken. It is likely that the situation will get worse over the next while as the ward is ordering a number of new beds that will continue to put holes in the walls unless a solution is found.

Outcome: The service reported that all remedial work had been completed by the builder or the maintenance department. An inspection of the premises confirmed this.

3. Multidisciplinary care plans must be introduced.

Outcome: Individual multidisciplinary care plans had not been introduced to St. Canice's and the service remained non-compliant with Article 15. The action plan submitted to the MHC Standards and Quality Assurance Division to remedy this non-compliance had not been progressed and the service reported this had been held up by industrial action earlier in the year. The industrial relations issue had since been resolved but no definite timeframe was available for when each resident in St. Canice's would have an individual care plan.

4. Regular six-monthly physical reviews should be carried out.

Outcome: A system for conducting the six-monthly physical examinations had been implemented. All of the clinical files reviewed during the inspection contained evidence of up-to-date physical examinations.

MDT CARE PLANS 2008

A multidisciplinary working group had been established to develop and implement individual care plans, and a standard form had been developed. The care plans were being piloted in the Department of Psychiatry, St. Luke's Hospital, Kilkenny. The care plan documentation included identification of risk factors, identification of initial needs/problems and ongoing needs, the action required and the person responsible for carrying out the action. There was space on the form to include the resident's views and signature. The care plan also included a discharge plan and a record of the dates and team members who attended meetings. Care plans must be introduced for all residents immediately.

GOOD PRACTICE DEVELOPMENTS 2008

- A multidisciplinary working group had developed a MDT care plan.
- A multidisciplinary clinical governance group had been established to review incidents and facilitate risk management in the service.
- A working group had researched a risk assessment tool for the service. This had not yet been implemented.
- Residents of St Canice's had been involved in a service audit regarding physical health and this had been used to inform a new policy on care of the physical health of patients who have been resident in approved centres in excess of six months.

SERVICE USER INTERVIEWS

A number of residents were introduced but none asked to formally meet with the Inspectorate.

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

1. Individual care plans for each resident must be introduced.

2. Therapeutic services and programmes must be provided in accordance with care plans.

3. The provision of information in an appropriate format to the residents on the two wards must be actioned.

4. The service should consider unit self-staffing to enhance the quality of care and treatment to residents by allowing nurses to specialise in particular areas.

5. Funding should be made available for dedicated health and social care professionals on the teams to enhance the quality of care and treatment to residents.

6. The residents in St. Canice's, in particular those on St Luke's Ward, should have individual assessments of need to determine appropriate placement, care and treatment requirements.

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 4 JUNE 2008

Article 6 (1-2) Food Safety

Food safety records, Hazard Analysis Critical Control Points (HACCP) meetings, water testing records and a recent report from the Environmental Health Officer dated February 2008 were reviewed. Minutes of meetings where outstanding issues were addressed and resolved were available to the Inspectorate.

Compliant: Yes

Article 8: Residents' Personal Property and Possessions

St. Canice's Hospital was using the HSE National Guidelines and had implemented a Carlow Kilkenny service policy that reflected local practice. This was made available to the Inspectorate.

Compliant: Yes

Article 15: Individual Care Plan

A system was being piloted in another approved centre. The service planned to implement this system in St. Canice's by October 2008.

Breach: None of the residents had individual multidisciplinary care plans.

Compliant: No

Article 16: Therapeutic Services and Programmes

St. Luke's Ward had an occupational therapist two days a week. A number of activities were facilitated but were not linked to care plans. The occupational therapist was from a different team, based on St. Gabriel's Ward. There was access to an art therapist, dietician, chiropodist and physiotherapist.

Breach: Therapeutic service and programme access was not in accord with individual care plans [Article 16 (1)].

Compliant: No

Article 17: Children's Education

The service provided a written statement that children were not admitted to St. Canice's Hospital.

Compliant: Yes

Article 18: Transfer of Residents

The service was compliant with this Article.

Compliant: Yes

Article 19 (1-2): General Health

A system for ensuring six monthly physical examinations were completed had been introduced and in the clinical files reviewed these were all up to date.

Compliant: Yes

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

There was no written information detailing the resident's multidisciplinary team or other aspects of care required under this Article. Staff reported that information was given in verbal format regarding medication and side effects, and only if requested. Following inspection the service reported that the Patient Advice Leaflets System had been purchased and delivery was awaited. In St. Luke's Ward, there was a white board that detailed the nursing staff on duty for the day. The Irish Advocacy Network (IAN) did not attend the ward on a regular basis, however there were notices detailing where that service could be contacted. A number of voluntary agencies attended St. Luke's Ward and provided recreational and spiritual input for the residents. The service reported that an information booklet would be available from August 2008. The ORCHID consumer information project was due to be available in St Canice's by the end of July 2008.

Breach: Information in an appropriate format was not provided as required [Article 20 (1)].

Compliant: No

Article 21: Privacy

The service was compliant with this Article.

Compliant: Yes

Article 22: Premises

All of the remedial work had been completed on St Gabriel's Ward.

Compliant: Yes

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

The medicine card index was up to date. A new prescription and recording booklet was due to be implemented.

Compliant: Yes

Article 24 (1-2): Health and Safety

Health and safety statements were available on St. Luke's and St. Gabriel's wards.

Compliant: Yes

Article 26: Staffing

All staff were recruited using the HSE recruitment, selection and vetting procedure. The nursing staff on both wards were part of a staffing roster that covered two approved centres and the community residences. Although there was some core staffing, the majority of staff rotated between these units. Residents on St. Luke's ward were under the care of the rehabilitation consultant but other members of the rehabilitation team were not involved in the ongoing care and treatment of these residents. The majority of the residents were at the later stage of life, a number had returned to the hospital from community residences because of physical reasons. Following inspection, the service reported that the rehabilitation consultant would be undertaking individual needs assessment that will determine appropriate placement, care and treatment requirements. Other mental health professionals will be available to support this process. Residents will be aligned with the service that most matches their needs.

St. Gabriel's Ward was under the care of the psychiatry of later life team. Visiting staff by referral included physiotherapist, speech and language therapist and chiropodist. There was an assistant director of nursing on duty at all times for the approved centre campus. Nursing staff had access to education and training.

Breach: The skill mix of staff on St. Luke's Ward was not sufficient to meet the needs of the residents as required by Article 26 (2).

Compliant: No

Article 28: Register of Residents

The service was compliant with this Article.

Compliant: Yes

Article 31: Complaint Procedures

The service had a complaints policy and appropriate information available outlining the procedures. There was a designated complaints officer. The record of complaints was reviewed by the Inspectorate.

Compliant: Yes

Article 32: Risk Management Procedures

Following inspection, the service reported that an adverse incident review group had been established and that it was planned that this group would feed into the clinical governance group monthly. The service reported plans to review individual risk management policies and to bring them under an umbrella policy document to comply with Article 32.

Breach: The plans for a comprehensive risk management policy document [Article 32 (1)] and systems for identifying trends and learning from adverse incidents were not yet in place [Article 32 (2)(d)].

Compliant: No

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

SECLUSION

The service provided a written statement to the Inspectorate that seclusion was not used in St. Canice's Hospital.

ECT

ECT was not administered in the approved centre and the service provided a written statement to the Inspectorate indicating that this rule was not applicable.

MECHANICAL RESTRAINT

Mechanical restraint was not used and the service provided a written statement confirming this and that only Part 5 was in use.

SECTION	DESCRIPTION	COMPLIANCE REPORT
21	**Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour**	A number of clinical files were reviewed. Cot sides, buxton chairs and lap belts were being used at the time of the inspection on St. Luke's and St. Gabriel's wards. These were clearly documented by the consultant psychiatrist in the clinical files and regular contact was documented in nursing notes about contact with next of kin in relation to risks to residents and the rationale for the use of such restraints.

Compliant: Yes

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

PHYSICAL RESTRAINT

Staff reported that physical restraint was not used in the approved centre. The approved centre had a policy on physical restraint. The Inspectorate draws attention to the requirement for this policy to be reviewed at least annually.

Compliant: Yes

ADMISSION OF CHILDREN

The hospital did not admit children and the service provided a written statement to the Inspectorate confirming that this code of practice was not applicable.

Compliant: Not applicable

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

The service had a policy regarding the notification of deaths and an appropriate system for recording incidents. A multidisciplinary clinical governance group including Irish Advocacy Network (IAN) representative, had been established to review incidents. Minutes of the meetings were reviewed by the Inspectorate.

There was limited access to a risk manager based in the general hospital. Following inspection, the approved centre reported that plans to achieve compliance with the Code of Practice would be implemented by mid-October.

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**	Non-compliant
4	**Clinical governance**	Non-compliant

Breach: The plans for a comprehensive risk management policy document, effective systems to implement Article 32, and governance arrangements were not yet in place [Section 4].

Compliant: No

ECT FOR VOLUNTARY PATIENTS

The hospital did not have ECT facilities and none of the residents were receiving ECT. The service provided a written statement to the Inspectorate indicating that this code of practice was not applicable.

Compliant: Not applicable

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

All residents were voluntary.

Compliant: Not applicable.