Report of the Inspector of Mental Health Services 2008

HSE AREA	Independent Sector
MENTAL HEALTH SERVICE	St Patrick's Hospital
APPROVED CENTRE	St Patrick's Hospital
NUMBER OF UNITS OR WARDS	7
UNITS OR WARDS INSPECTED	Dean Swift Unit Stella Unit Eating Disorder Unit ECT Suite
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	231
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	20/21 May 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.

St. Patrick's Hospital provides a private inpatient mental health service and accepts referrals nationally. The service is now in the process of developing a community based service with plans to have community services regionally throughout the country. It also provides an eating disorder service.

DESCRIPTION

There were seven units in the hospital, with a total bed capacity of 231 beds. It was reported that there were plans to further develop sub-specialties within each unit. There were 13 consultant psychiatrists with admitting rights to the hospital. Awide range of therapeutic services and programmes was provided.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	SPECIALTY
Dean Swift	31	31	Acute admission
Stella	31	31	Female admission
Grattan	35	35	Mixed admission
Vanessa	33	33	Elderly female
Delaney	32	32	Male admission
Laracor	38	38	Alcohol and substance misuse
Kilroot	31	31	Male admission

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. Each resident should have an individual multidisiplinary care and treatment plan.

Outcome: There had been some progress on this recommendation, although not all residents had a care plan that reflected multidisciplinary input.

2. All disciplines should record interventions in the resident's file at regular and timely intervals.

Outcome: In Dean Swift Unit, there was evidence that all disciplines recorded interventions in the integrated file. This process had commenced in Stella Unit.

3. Attendance at therapeutic programmes should be linked to the individual care plan and nursing staff should be aware of each resident's plan and the location of residents.

Outcome: In Dean Swift Unit, there was evidence that therapeutic interventions were linked to care plans. In Stella Unit, the nursing staff were aware of the residents programme and location. The development of individual care plans linked to therapeutic activities was being developed. It was reported by senior management that this work had commenced.

4. There should be a consistent approach to multidisciplinary team functioning across all the wards.

Outcome: The process was being developed. It had commenced in Dean Swift Unit.

5. Peer advocacy services should be developed within the hospital.

Outcome: The Irish Advocacy Network (IAN) was providing peer advocacy in the hospital.

MDT CARE PLANS 2008

The hospital had developed a new system of recording care planning and multidisciplinary team working. It had been implemented in Dean Swift Unit initially and was been rolled out throughout the hospital. Dean Swift Unit was now under the clinical direction of one consultant psychiatrist and clinical team.

Dean Swift Unit: It was evident that there had been progress in implementing a new care plan. Recording of multidisciplinary input was limited to record of attendance at team meetings and did not outline responsibility for implementing the care plan. In most cases all disciplines attended the team meetings. Formal assessments of nursing and medical needs were carried out, as was risk assessment. The service user's own input into the care plan was recorded and signed by them. Interventions were recorded in the continuation sheets by all disciplines, including pharmacy, and were chronological. Some service users stated that they were unaware of their care

plans although they had signed their own plans. No unmet needs were recorded. All residents were assigned a primary nurse. All records and the care plan were in one document, were neat and tidy and easy to follow.

Stella Unit: A single multidisciplinary care plan was in place for all new residents admitted to the ward. It included a medical and nursing assessment on admission. Interventions were recorded in the continuation sheets by all disciplines. Attendance at team meeting was recorded using an interdisciplinary team meeting sheet. It was evident in the files reviewed that attendance at team meetings was mainly by medical and nursing staff. The development of an individualised care plan was at an early stage.

GOOD PRACTICE DEVELOPMENTS 2008

- The community service was being developed with one team operating in Dublin and plans for further teams in the Midlands and in North County Dublin.
- Focused teams in cognitive behavioural therapy, eating disorder, ECT, psychiatry of later life, dual diagnosis, affective disorder and psychosis had been consolidated.
- The process allowing a member of the consumer panel to attend a number of Board meetings was being finalised.
- Plans were under way to reconstruct an area of the hospital into an adolescent unit that would also provide an eating disorder service as well as a general adolescent mental health service. Recruitment for a child and adolescent psychiatrist was underway.
- A randomised clinical trial (RCT) on the effectiveness of ECT had commenced.

SERVICE USER INTERVIEWS

Dean Swift Unit: All service users interviewed were satisfied with the care, treatment and accommodation. Two service users stated that they were unaware of their care plans.

Stella Unit: A number of residents were spoken to during the inspection. They all expressed global satisfaction with the service.

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

1. Each resident should have an individual multidisciplinary care and treatment plan.

2. Enhanced multidisciplinary team functioning should be developed across all the units.

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 20/21 MAY 2008

Article 6 (1-2) Food Safety

The service was compliant.

Compliant: Yes

Article 12 (1-4): Communication

A policy for communication was now in place.

Compliant: Yes

Article 13: Searches

The policy on searches, which covered consent and the presence of two staff, was now in place.

Compliant: Yes

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

A policy was now in place that met the requirements of this Article.

Compliant: Yes

Article 15: Individual Care Plan

Dean Swift Unit: Multidisciplinary individual care plan forms were filed in all files reviewed. Initial medical, nursing and risk assessments were in place and goals were identified. Attendance at multidisciplinary team meetings by team members was recorded in some files. Each care plan was reviewed at a weekly team meeting and the review recorded.

Stella Unit: Six files were reviewed. The individual care plans did not meet the requirements as defined in the Regulations. A detailed action plan to address this was submitted to the Inspectorate.

Breach: Article 15

Compliant: No

Article 16: Therapeutic Services and Programmes

Dean Swift Unit: There was an occupational therapist in Dean Swift who provided therapeutic programmes, including art and pottery. Residents could also be referred to specific treatment programmes, e.g. eating disorder, alcohol treatment, anxiety management, or bipolar disorder. There was evidence that attendance at specific programmes was recorded as part of the individual care plan.

Stella Unit: There was evidence that each resident had access to a wide range of therapeutic services and programmes. Each resident had an individual copy of the programmes available throughout the hospital. There was no evidence in the files reviewed that the programmes were linked to an individual care plan. A detailed action plan to address this was submitted to the Inspectorate.

Breach: Article 16 (1)

Compliant: No

Article 17: Children's Education

Grattan Ward: The hospital had admitted children to a separate unit with three beds. One bed for male patients was available in Kilroot ward. There were no structured educational programmes provided but liaison was maintained with the school of origin where appropriate. There was a policy on education arrangements for children, clinical programmes for young adults and policies around admission.

Compliant: Yes

Article 18: Transfer of Residents

The service had policies in place relation to the transfer of residents.

Compliant: Yes

Article 19 (1-2): General Health

There was a physician attached to the hospital. The clinical file of a patient in Dean Swift Unit for more than six months was examined and indicated that an up-to-date medical examination was carried out. Relevant policies were in place.

Compliant: Yes

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

An orientation package was provided to all admissions and underpinned in a policy on information provision. Peer advocacy was provided by the Irish Advocacy Network (IAN).

Compliant: Yes

Article 21: Privacy

There were adequate provision made for residents right to privacy.

Compliant: Yes

Article 26: Staffing

The service was currently progressing Garda vetting for existing staff. Vetting procedures for new staff were already in place. The service submitted an action plan to address this and stated it would be compliant by the end of the year. All staff had received a one-day training course in the Mental Health Act. A copy of the Mental Health Act 2001 was available in the Dean Swift Unit.

On the units admitting children, the Code of Practice in relation to children was still not available. Evidence was sent to the Inspectorate verifying that this had been corrected.

Breach: Article 26 (1)

Compliant: No

Article 28: Register of Residents

The service had an electronic register that contained all the elements of Schedule 1. The service reported that residents were unwilling to give their Personal Public Service (PPS) numbers in some cases.

Compliant: Yes

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

SECLUSION

Dean Swift Unit: Although the service reported that seclusion was not used in the hospital, there was a seclusion suite. A seclusion policy was available but there were no registers on the units. The service subsequently sent a policy to the Inspectorate stating that seclusion was not used.

Compliant: Not applicable

ECT

Three files were reviewed and the ECT suite was inspected.

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**	Compliant
3	**Information**	Compliant
4	**Absence of consent**	Compliant
5	**Prescription of ECT**	Compliant
6	**Patient assessment**	Compliant
7	**Anaesthesia**	Compliant
8	**Administration of ECT**	Compliant
9	**ECT Suite**	Compliant
10	**Materials and equipment**	Compliant
11	**Staffing**	Compliant
12	**Documentation**	Compliant
13	**ECT during pregnancy**	Compliant

Compliant: Yes

MECHANICAL RESTRAINT

The hospital had a policy prohibiting the use of mechanical restraint for any reason. No files were reviewed during the inspection.

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

SECTION	DESCRIPTION	COMPLIANCE REPORT
14	**Orders**	Not applicable
15	**Patient dignity and safety**	Not applicable
16	**Ending mechanical restraint**	Not applicable
17	**Recording use of mechanical restraint**	Not applicable
18	**Clinical governance**	The hospital had a policy prohibiting the use of mechanical restraint for any reason. Staff reported that mechanical restraint was not used. There was a policy that covered both mechanical restraint and physical restraint.
19	**Staff training**	Not applicable
20	**Child patients**	Not applicable
21	**Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour**	**Vanessa Unit:** All restraint under Part 5 of the Act was stated to be documented in the resident's file and that the only form of restraint under Part 5 was the use of cot sides. No resident has been restrained for a number of months prior to the inspection. The service subsequently forwarded a policy on mechanical restraint to the Inspectorate.

Compliant: Yes

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

PHYSICAL RESTRAINT

Physical restraint was occasionally used in the special care unit. Case files were examined and all contained the clinical practice forms for 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**	Compliant
3	**Resident dignity and safety**	Compliant
4	**Ending physical restraint**	Compliant
5	**Recording use of physical restraint**	Compliant
6	**Clinical governance**	There was a policy that covered both Mechanical Restraint and Physical Restraint
7	**Staff training**	Compliant
8	**Child residents**	Not applicable

The service subsequently forwarded a separate policy on physical restraint to the Inspectorate.

Compliant: Yes

ADMISSION OF CHILDREN

The senior management team reported that plans to develop a 10-bed in-patient unit and to recruit an adolescent consultant psychiatrist. Garda vetting had commenced in December 2006 and staff working with children had been prioritised.

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**	Children may be admitted to specified single-gender general adult wards and the Eating Disorder Unit. The Mental Health Commission had been notified of all admissions using the clinical practice form. Copies of the forms were in the individual care files. All children admitted to the hospital were under the care of a general adult consultant psychiatrist. Advice was available from a Child and Adolescent psychiatrist as required. Policies and procedures were in place relating to the admission of children. All young people were accommodated in single rooms.
3	**Treatment**	The hospital was unable to provide evidence that it was meeting its requirements under the code in relation to parental consent.
4	**Leave provisions**	Compliant

Subsequent to the inspection, the service submitted a policy that met its requirements under the Code of Practice in relation to parental consent.

Compliant: Yes

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

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

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Consent**	Compliant
3	**Information**	Compliant
4	**Prescription of ECT**	Compliant
5	**Assessment of voluntary patient**	Compliant
6	**Anaesthesia**	Compliant
7	**Administration of ECT**	Compliant
8	**ECT Suite**	Compliant
9	**Materials and equipment**	Compliant
10	**Staffing**	Compliant
11	**Documentation**	Compliant
12	**ECT during pregnancy**	Compliant

Compliant: Yes

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

This was not inspected on the day of the inspection.

Compliant: Not applicable