Report of the Inspector of Mental Health Services 2008

HSE AREA	HSE South
CATCHMENT	South Tipperary
MENTAL HEALTH SERVICE	South Tipperary
APPROVED CENTRE	St. Luke's Hospital, Clonmel
NUMBER OF UNITS OR WARDS	5
UNITS OR WARDS INSPECTED	St. Paul's, St. Mary's, St. Bridget's (ID), St. Theresa's, St. John's
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	106
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	12 and 20 November 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. Luke's Hospital provides in-patient care for North and South Tipperary. Clinical care was provided by consultant psychiatrists from both catchments in a locally devised agreement. Clinical care and treatment was provided to elderly care, rehabilitation, continuing care, intellectual disability and a locked male general adult ward. The total bed capacity was 106 beds over five wards. In addition, the services had access to 48 acute beds in South Tipperary General Hospital. Since the inspection in 2007, St. Claire's Ward had closed.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
St. Paul's	22	20	Named consultant
St. Mary's	23	22	Psychiatry of later life team
St. Bridget's (intellectual disability)	19	19	Named consultant
St. Theresa's	22	16	Rehabilitation team
St. John's	20	20	Various consultants

On the day of the inspection, the Inspectorate had serious concerns regarding the care and treatment of residents in St. Bridget's Ward and St. John's Ward. These concerns were immediately reported to the Registered Proprietor and the Mental Health Commission. The other wards were inspected on the 20 November 2008.

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. Admissions to the hospital should cease.

Outcome: There was no progress on this recommendation. There were 19 admissions in total. Five were to St. John's Ward, including one first admission.

2. The planned closure of wards should progress and appropriate placements arranged for individuals based on need.

Outcome: St. Claire's Ward had closed since the 2007 inspection. The majority of residents had been placed in nursing home accommodation. The other residents remaining in hospital were placed in other wards within the approved centre.

3. The development of individual care plans for each resident should be implemented.

Outcome: This was at pilot stage on St. Theresa's Ward. There was no timescale provided for the full implementation throughout the approved centre. It was subsequently reported that the pilot was of six months' duration.

4. Therapeutic activities should be based on individual need following assessment.

Outcome: This was not consistently available to all residents on each ward.

5. The programme of refurbishment should continue.

Outcome: There did not appear to be a planned programme of refurbishment. Serious deficits were identified during the inspection on St. Bridget's Ward.

MDT CARE PLANS 2008

MDT care plans and integrated notes were still at pilot stage. There was strong evidence demonstrating the effectiveness of integrated notes and care planning on St. Theresa's Ward. A considerable amount of work and training had been completed to ensure all staff were aware of the process. It was reported that all new admissions to continuing care would commence using the new system.

GOOD PRACTICE DEVELOPMENTS 2008

- Seclusion had ceased on St. Bridget's Ward.
- St. Paul's Ward and St. Mary's Ward had developed locked door policies.
- The Vocational Educational Committee (VEC) provided a number of art sessions weekly to the elderly care wards.
- A physiotherapy service based on need was provided on St. Paul's Ward.

SERVICE USER INTERVIEWS

A number of service users on St. John's Ward asked to meet with the Inspectorate team. They had a number of concerns regarding the replacement renewal orders. Others spoke of the lack of activities on the ward. The residents had no regular access to an advocate. On the other wards, all the residents were spoken to informally. A number of residents were unable to communicate or lacked capacity to voices issues.

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

1. Lines of accountability must be put in place to ensure that all residents are reviewed by their clinical team in a timely manner.

2. Transfers between two different approved centres (St. Michael’s Unit and St. Luke’s Hospital) for the purpose of providing more admission beds (also known as ‘sleeping out’) was not acceptable practice.

3. Residents must have access to a regular peer advocacy service.

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 12 AND 20 NOVEMBER 2008

Article 6 (1-2) Food Safety

A copy of a recent report was given to the Inspectorate team.

Compliant: Yes

Article 15: Individual Care Plan

The service had developed an MDT care planning system. It was at a pilot stage at the time of inspection on St. Theresa's Ward. There was a single integrated file in operation. It was planned to include all wards in the new system. No timescale was available on the day of the inspection. It was subsequently reported that the pilot would be completed within six months. The files reviewed on the St. Theresa's Ward were in order. There was clear evidence of MDT input with all residents. In St. Bridget's Ward, there was evidence that regular psychiatric reviews for eight residents had not taken place in a timely manner. Photographic evidence was taken.

Breach: Article 15

Compliant: No

Article 16: Therapeutic Services and Programmes

There were speciality teams in psychiatry of later life and rehabilitation with input in St. Theresa's Ward and St. Mary's Ward. In St. Theresa's Ward, there was clear evidence that therapeutic service and programmes were linked to an individual care plan. In St. Mary's Ward, the occupational therapist recorded interventions in the nursing notes and there were weekly team meetings. A physiotherapy service was provided on the ward as required. There was no individual care plan at the time of inspection. There was a plan to include occupational therapy sessions into St. Paul's Ward from December 2008. There was limited access to health and social care professionals on the other wards. On St. Bridget's Ward, residents were observed to be wandering aimlessly and some exhibited behaviours that suggested a lack of external stimulation. There was no access to therapeutic programmes, services or even basic equipment on the day of the inspection.

Breach: Article 16

Compliant: No

Article 17: Children's Education

The approved centre did not admit children.

Compliant: Not applicable

Article 18: Transfer of Residents

Transfers to other approved centres were through consultant psychiatrist to consultant psychiatrist contact over the telephone, the consultant psychiatrist's referral letter and a nursing assessment. A written operational policy and procedures on the transfer of residents had been in place since November 2007 and were due for review in November 2010.

During the course of the inspection evidence emerged that residents from South Tipperary General Hospital were transferred to St. Luke's Hospital. It was immediately highlighted to the service that these were two separate approved centres and the process must be in compliance with the Mental Health Act 2001. A number of residents from South Tipperary General Hospital were 'sleeping out' in St. Luke's. This was not in compliance with the Mental Health Act 2001.

Breach: Residents were transferred for the purpose of providing admission beds and not to receive treatment [Article 18].

Compliant: No

Article 19 (1-2): General Health

A large number of files were checked on all wards for the biannual physical examinations. They were in order. There was a system in place to ensure the NCHD completed the examinations on time. It was reported that all female residents were offered breast check screening. The flu vaccine was offered to all residents and recorded in the clinical file.

Compliant: Yes

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

A general information booklet was available. St. Paul's Ward was localising this booklet. Details of each resident's multidisciplinary team were available on each ward. Details of the Irish Advocacy Network advocate were visible on each ward. However there was no regular service to the approved centre.

A written operational policy and procedures on provision of information to relatives had been in place since November 2007 and were due for review in November 2010.

Staff reported that the doctors explained the purpose of medication and side effects at the time that it had been prescribed and whenever requested by the resident. There was no evidence of a system in place for the routine provision of written information regarding treatment although management stated that information files were available.

Breach: Article 20 (1)(e)

Compliant: No

Article 21: Privacy

All beds in dormitories in all wards had curtains around the bedside. Lower windows were frosted or had net curtains. Deficits identified in the previous year's report had been rectified.

Compliant: Yes

Article 22: Premises

St. John's Ward: A ligature point was identified on the ward. This was brought to the immediate attention of the senior management team. The wards was unsuitable for the care and treatment of residents especially those with severe mental illness. The environment was institutionalised, with a large day room and a lack of therapy areas.

St. Paul's Ward: A number of deficits identified in last years report had been rectified.

St. Bridget's Ward: The condition of a number of bedrooms for men was uninhabitable. There was an overpowering smell of urine. The rooms were devoid of any stimulation or homely features. Photographic evidence was taken. This was brought to the immediate attention of the senior management team. The rooms were closed on the day of inspection pending full refurbishment. This was reported to have commenced on 20 November 2008.

St. Theresa's Ward: The shower on the ground floor was in a poor state.

St. Mary's Ward: There were insufficient bathrooms for an elderly and heavily dependent population. Efforts had been made to make the ward as homely as possible

Breach: Article 22 (1), Article 22 (2), and Article 22 (3).

Compliant: No

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

A policy was available.

Compliant: Yes

Article 26: Staffing

The HSE policy in relation to the recruitment, selection and vetting of staff was in place. Care and treatment was primarily delivered by nursing and medical staff. Each ward had household staff during the day, up to 1800h. There was always an assistant director of nursing on duty during the day, and a night superintendent during the night. No team had a full complement of multidisciplinary staff. This had a direct impact on the range of treatment interventions available to the residents. It was reported that the provision of occupational therapy input would be prioritised in 2009.

Breach: There were insufficient health and social care professional staff to provide an adequate therapeutic programme appropriate to the needs of the residents [Article 26 (2)].

Compliant: No

Article 31: Complaint Procedures

There were two complaints systems in place, a local system and the national HSE procedure. A written operational policy and procedures relating to complaints had been in place since November 2007 and were due for review in November 2010. A record of complaints was given to the Inspectorate.

Compliant: Yes

Article 32: Risk Management Procedures

The risk management policies were in draft form. It was reported that the risk manager, clinical director and director of nursing meet on a fortnightly basis to review all incidents. The risk manager reported that there were plans to broaden the composition of the group to include health and safety, hospital manager and a representative from health and social care professionals.

The incident book on St. Mary’s Ward was not in duplicate. It was stated that all incidents were reviewed by the clinical risk management group.

The Sainsbury Centre for Mental Health risk assessment was being completed on a number of residents.

Breach: Only a draft policy on risk management was in place [Article 32 (1)].

Compliant: No

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

SECLUSION

Seclusion had ceased on St. Bridget's Ward since the last inspection. There was one seclusion room on St. John's Ward. The seclusion register was reviewed together with one clinical file.

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**	Compliant
3	**Patient dignity and safety**	Compliant
4	**Monitoring of the patient**	Compliant
5	**Renewal of seclusion orders**	Compliant
6	**Ending seclusion**	There was no evidence in the file reviewed that the resident had been given an opportunity to review his period in seclusion with the MDT.
7	**Facilities**	Compliant
8	**Recording**	Compliant
9	**Clinical governance**	There was no evidence in the file reviewed that the resident's MDT had reviewed the period in seclusion. A policy was available. A copy of the annual report was requested by the Inspectorate team.
10	**Staff training**	Some but not all staff were trained in physical restraint. There were ongoing difficulties with providing replacement staff.
11	**CCTV**	Compliant
12	**Child patients**	Not applicable

Breach: Not all staff were trained in physical restraint.

Compliant: No

ECT

The approved centre did not have ECT facilities and no resident was receiving a programme of ECT.

Compliant: Not applicable

MECHANICAL RESTRAINT

Staff reported that mechanical restraint was not in use in the hospital on the day of the inspection.

SECTION	DESCRIPTION	COMPLIANCE REPORT
21	**Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour**	A number of residents in St. Mary's Ward and St. Paul's Ward were prescribed restraints. This prescription was made following a falls assessment and bed rail assessment. These assessments were completed by the nursing staff and available in the nursing notes. The prescription did not indicate the duration of restraint. This was identified as a breach in 2007. A copy of the prescription was available in the front of the chart.

On St. Bridget's Ward one resident had been prescribed bed rails. A review due on 23 October 2008 had not been completed.

Breach: The prescriptions did not indicate the duration of restraint.

Compliant: No

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**	Compliant
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**	Non-compliant. Some but not all staff were trained in physical restraint. There were ongoing difficulties with providing replacement staff.
8	**Child residents**	Not applicable

Breach: Not all staff were trained in physical restraint.

Compliant: No

ADMISSION OF CHILDREN

No children were admitted to the approved centre in 2008.

Compliant: Not applicable

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**	Non-compliant. The service was not compliant with Article 32 of the Mental Health Act 2001 Regulations.
4	**Clinical governance**	All policies were in draft form. It was reported that the interim policies were under review by the new clinical governance structures.

Breach: The service was not compliant with Article 32 of the Mental Health Act 2001 Regulations.

Compliant: No

ECT FOR VOLUNTARY PATIENTS

The approved centre did not have ECT facilities and no resident was receiving a programme of ECT.

Compliant: Not applicable

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

There was no resident who met the criteria on the day of inspection.

Compliant: Not applicable