Report of the Inspector of Mental Health Services 2012

EXECUTIVE CATCHMENT AREA/INTEGRATED SERVICE AREA	Limerick, North Tipperary, Clare
HSE AREA	West
MENTAL HEALTH SERVICE	Limerick
APPROVED CENTRE	St. Joseph's Hospital
NUMBER OF WARDS	1
NAMES OF UNITS OR WARDS INSPECTED	Aurora
TOTAL NUMBER OF BEDS	16
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	16 April 2012

Summary

- The kitchen and toilets in the approved centre were not clean.
- Most residents did not have an individual care plan as described in the Regulations.
- There was a lack of therapeutic programmes available to residents.
- Clinical documentation did not reflect risk assessment and risk management, essential to support successful transfer of residents to the community.
- Training in physical restraint had not been provided. This was a recommendation in the 2011 Inspector of Mental Health Services Report.

OVERVIEW

In 2012, the Inspectorate inspected this Approved Centre against all of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

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 2011. In addition to the core inspection process information was also gathered from self-assessments, service user interviews, staff interviews and photographic evidence collected on the day of the inspection.

This approved centre inspection was part of a wider whole service evaluation of the Limerick Mental Health Services over a four day period from 16 July to 19 July 2012 inclusive.

DESCRIPTION

St. Joseph's Hospital was built in 1825 and was an approved centre under the Mental Health Act 2001. Over recent years most of the remaining wards had closed and residents transferred to either nursing home care or residential care in the community mental health services. Aurora Ward was the last ward remaining in the approved centre. The all-male ward had sixteen residents on the day of inspection, one of whom was detained as an involuntary patient under the Mental Health Act 2001.

SUMMARY OF COMPLIANCE WITH MENTAL HEALTH ACT 2001 (APPROVED CENTRES) REGULATIONS 2006

COMPLIANCE RATING	2010	2011	2012
Fully Compliant	25	20	13
Substantial Compliance	0	1	8
Minimal Compliance	1	5	2
Not Compliant	3	3	6
Not Applicable	2	2	2

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

DETAILS OF WARDS IN THE APPROVED CENTRE

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Aurora	16	16	Rehabilitation and General Adult

QUALITY INITIATIVES 2011/2012

- A risk register had been developed at clinical level and at supercatchment level.
- The clinical files had been redesigned.

PROGRESS ON RECOMMENDATIONS IN THE 2011 APPROVED CENTRE REPORT

1. The hospital should close.

Outcome: Aurora ward was the only remaining ward in the approved centre with 16 residents. Plans were afoot to close this ward in 2012.

2. Individual care plans must record resources required to meet assessed need and who should provide this.

Outcome: The majority of individual care plans examined by inspectors did not record the resources required to meet assessed need.

3. Therapeutic services and programmes must be linked to assessed need.

Outcome: In the clinical files examined there was no evidence that therapeutic services and programmes were linked to assessed need.

4. Records must be maintained in an accessible and legible manner. Medical staff signatures should be identifiable and medical council numbers should be included, especially on prescriptions.

Outcome: Records were maintained in an accessible and legible manner but medical staff were not using their medical council numbers in most cases.

5. Staff training in the application of physical restraint must be updated.

Outcome: This had not occurred.

6. Individual risk assessment and management plans must be updated.

Outcome: Documented risk assessment and management was absent from the majority of clinical files examined by inspectors.

7. The Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre should be accurately implemented.

Outcome: Inspection of clinical files revealed the Code had not been accurately implemented.

8. The treating consultant psychiatrist should ensure that documentation relating to either discharge or transfer is complete and clear in intention.

Outcome: Inspection of clinical files revealed the Code had not been accurately implemented.

9. The approved centre must comply with Article 31 Complaints Procedure.

Outcome: The complaints policy was made available to inspectors.

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

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

Article 4: Identification of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Two registered psychiatric nurses administered medication. Photographic identification was stored in the residents' clinical files.

Article 5: Food and Nutrition

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a good choice of main meal on the menu which was displayed on the ward. Food was freshly cooked. Breakfast, including porridge, was supplied by the kitchens of the approved centre. The main meal and evening meal were supplied by St. Camillus' Hospital in suitable hot containers designed for such a purpose. A supply of fresh drinking water was available.

Article 6 (1-2): Food Safety

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			X

Justification for this rating:

The ward kitchen from which food was distributed was grubby in appearance and worktop surfaces, sink and equipment such as the hob, toaster etc., had ingrained grime and dried-up food residue and had not been adequately cleaned. Photographic evidence was taken. It was reported by staff that a member of the domestic staff had not been assigned to this area of the ward for at least a week prior to the inspection because of budgetary cuts. The most recent food safety report by the environmental health officer, requested for examination on the day of inspection by inspectors, was made available to inspectors by the time this whole service evaluation inspection was completed on the fourth day.

A letter was sent to the registered proprietor of the approved centre seeking assurance that the kitchen and toilets had been deep cleaned following the inspection. Assurances in writing, as well as photographs, were subsequently received by the Inspectorate from the approved centre that the situation had been remedied.

Breach: 6(1)(c), (2)(c)

Article 7: Clothing

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

An adequate supply of clothing was available if required which would then become the property of the receiving resident. Night clothes were not worn by residents during the day. Although the service made a considerable effort to have all clothing labelled on inspection of some clothing, particularly underwear and socks, it was apparent that this had not been achieved.

Breach: 7(1)

Article 8: Residents' Personal Property and Possessions

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The approved centre had written operational policies and procedures relating to residents' personal property and possessions. A triplicate record was maintained of each resident's personal property and possessions. A financial account statement of residents' personal monies was present in each resident's clinical file. Staff were asked to remove these by inspectors and keep such financial statements in a more appropriate, secure and private place. This was completed on the day of inspection. Each resident retained control of their own personal property and possessions except in a small number of cases for clinical reasons but these were not recorded in the respective residents' individual care plans. Reasonable provision was made to ensure the safe-keeping of all residents' personal property and possessions.

Breach: 8(5)

Article 9: Recreational Activities

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

A number of residents stated that they were unhappy that the Activation Centre nurse had not been replaced. Art therapy took place every Thursday but apart from that, residents said they were bored. A number of residents relied on being accompanied by staff in order to go outside in the air and because of shortages of staff on the ward on the day of inspection this could not be facilitated. Day trips were also curtailed by this. There was a TV in the day area of the ward. Newspapers were delivered to the unit for residents.

Breach: 9

Article 10: Religion

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Residents were facilitated in the practice of their religion.

Article 11 (1-6): Visits

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was a comfortable and spacious visiting room on the ward. Visiting times were stated to be 1400h-1600h and 1830h-2030h but they were also flexible to reasonably accommodate visitors when necessary. It was reported that no fire drills took place on the ward. In light of this, as well as non-availability to inspectors of documentation of inspections relating to fire, inspectors were unable to determine whether the approved centre took all reasonable steps to ensure the safety of residents and visitors. A room immediately outside the ward could be used in the event of a child visitor; all child visitors had to be accompanied by a responsible adult. The approved centre had written operational policies and procedures for visits.

Breach: 11(3)

Article 12 (1-4): Communication

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Residents sent and received mail. The approved centre had written operational policies and procedures on communication. Some residents used mobile phones.

Article 13: Searches

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

No search had been carried out in 2012 to the date of inspection. The approved centre had all appropriate written operational policies and procedures to satisfy this Article.

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

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There had been no death in 2012 to the date of inspection. A single room could be availed of if circumstances arose. The approved centre had written operational policies and protocols for care of residents who are dying.

Article 15: Individual Care Plan

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*			
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*		X	
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*	X		X

Justification for this rating:

One resident did not have an individual care plan (ICP). One resident had an ICP as described in the Regulations. In the remaining clinical files examined all residents had ICPs but not as described in the Regulations. As in the 2011 inspection, ICPs, in most cases, did not record the resources required to meet assessed need and did not indicate who should provide for this.

Breach: 15

Article 16: Therapeutic Services and Programmes

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*			
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*	X	X	
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			X

Justification for this rating:

Therapeutic services and programmes were not based on assessed need and were not linked to individual care plans. Of the clinical files inspected, there was evidence in one of the files of interventions by the psychologist on the team. Two residents articulated to inspectors how the retirement of the Activation Nurse earlier in the year had impacted on their need for such programmes. Both stated they were bored on the ward and had nothing to do. Three registered nurses were on duty on the ward on the day of inspection instead of the required four registered nurses and this impacted negatively on any therapeutic activities taking place on that day.

Breach: 16(1), (2).

Article 17: Children's Education

Children were not admitted to the approved centre.

Article 18: Transfer of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X		X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*		X	
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

All relevant documentation accompanied a resident who was being transferred. The approved centre had a written operational policy and procedures on the transfer of residents.

Article 19 (1-2): General Health

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			X

Justification for this rating:

Adequate arrangements were in place for access by residents to general health services. One resident had not received a physical examination since June 2011. The approved centre had written operational policies and procedures for responding to medical emergencies.

Breach: 19(1)(b).

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

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X		
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*		X	
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Information on personal property, mealtimes, visiting times and visiting arrangements was supplied in the “Information for In-patients/Residents” booklet. Written information on residents’ diagnoses was available. Contact details of the peer advocate, who called regularly to the unit, were displayed. Written information on indications for use of all medications to be administered to the residents, including any possible side-effects was not provided in an understandable form. The approved centre had written operational policies and procedures for the provision of information to residents.

Breach: 20(1)(e)

Article 21: Privacy

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Shower doors could not be locked. The large dormitory, although having privacy curtains, could no longer be considered appropriate.

Breach: 21

Article 22: Premises

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*			
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*	X	X	X

Justification for this rating:

The kitchen and toilets were grubby and grimy. The ward kitchen from which food was distributed was grubby in appearance and worktop surfaces, sink and equipment such as the hob, toaster etc., had ingrained grime, and dried-up food residue and had not been adequately cleaned. The outside wall panels of the toilet cubicles were in need of deep cleaning. Faeces was smeared on the inside wall of one cubicle. There was a pervading smell of urine emanating from the toilet area into the immediate vicinity of the ward. Deep cleaning was required immediately for both kitchen and toilets and this was made known to staff of the approved centre by inspectors. Photographic evidence was taken. The approved centre was not maintained in a clean and hygienic condition with due regard to the safety and well-being of residents such as to satisfy section 3 of this Article. Maintenance of the physical structure of the unit was reported to be good. The ward was adequately and suitably furnished.

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The approved centre had appropriate and suitable practices and a written operational policy relating to the ordering, prescribing, storing and administration of medicines to residents.

Article 24 (1-2): Health and Safety

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The Health and Safety Statement was available for examination by inspectors. It was reported that no fire drills had been recently carried out. Documentation of inspections relating to fire was not made available to inspectors despite a number of verbal and written requests for such documentation to be provided.

Breach: 24(2)

Article 25: Use of Closed Circuit Television (CCTV)

CCTV was not used in the approved centre.

Article 26: Staffing

WARD OR UNIT	STAFF TYPE	DAY	NIGHT
Aurora	Nursing	4 RPNs (3 RPNs on the day of inspection)	2 RPNs

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Non Consultant Hospital Doctor (NCHD),Director of Nursing, (DON), Assistant Director of Nursing (ADON).

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*			
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*	X	X	X

Justification for this rating:

HSE policies relating to recruitment, selection and vetting of staff applied. It was reported by staff of the approved centre that the full complement of nursing staff was not on duty on the day of inspection. No occupational therapist attended the approved centre and in addition to this, the activation nurse who had transferred to another part of the service had not been replaced. There was an appropriately qualified staff member on duty and in charge of the approved centre at all times. The training register in relation to the training and education of nursing staff was made available to inspectors. The training register for medical staff and Health and Social Care Professionals was not made available. Staff had not received training in relation to physical restraint. Copies of the Mental Health Act 2001, Regulations, Rules and Codes of Practices were available on the ward to staff.

Breach: 26(2), (4)

Article 27: Maintenance of Records

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X		
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*		X	X
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Medical council numbers were still not being used in documentation in clinical files and in prescriptions of medications and therefore records were not complete. This had been a recommendation of the 2011 inspection report. The approved centre had a written policy and procedures on Recording Clinical Information, but this did not include a policy and procedures relating to the retention of and destruction of records. Documentation relating to health and safety, and the most recent environmental health officer's report on food safety was available. Documentation of inspections relating to fire was not made available to inspectors by the fourth day of this Whole Service Evaluation inspection. This was again requested verbally and in writing by the Inspectorate subsequent to the inspection but was not forwarded.

Breach: 27(1), (2), (3).

Article 28: Register of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The Register of Residents was examined by inspectors and was compliant with Schedule 1 to the Regulations.

Article 29: Operating policies and procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			X
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Not all policies of the approved centre were made available to inspectors in order to determine that they were reviewed at least every three years.

Breach: 29

Article 30: Mental Health Tribunals

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Facilities were available for the facilitation of Mental Health Tribunals. Appropriate assistance was provided by staff of the approved centre to patients of the approved centre.

Article 31: Complaint Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X		X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*		X	

Justification for this rating:

The approved centre's operational policy and procedures relating to the making and handling of complaints was made available to inspectors for examination. The complaints procedure was highlighted in a prominent location on the ward. A nominated person was available in the approved centre to deal with all complaints. A record of complaints was made available to inspectors.

Article 32: Risk Management Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X		
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*		X	
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			X
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The Risk Management policy examined by inspectors failed to satisfy the requirements of Article 32 in that in many of the clinical files examined by inspectors, recording of risk assessment and risk management, essential to support successful transfer of residents from St. Joseph's Hospital, was absent. This was a recommendation in the 2011 inspection report.

Breach: 32(1)

Article 33: Insurance

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The approved centre was insured under the HSE insurance scheme and this certificate was examined by inspectors on the day of inspection.

Article 34: Certificate of Registration

LEVEL OF COMPLIANCE	DESCRIPTION	2010	2011	2012
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The Certificate of Registration was framed and displayed in a prominent position in the approved centre.

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

SECLUSION

Use: Seclusion was not used in the approved centre and the service had a policy which stated this.

Electroconvulsive Therapy (ECT) (DETAINED PATIENTS)

Use: ECT was not administered in the approved centre and no detained patient was in receipt of a programme of ECT at another location outside the approved centre.

MECHANICAL RESTRAINT

Use: Mechanical restraint including mechanical restraint under Part 5 of the Rules Governing the Use of Mechanical Restraint was not used in the approved centre.

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

PHYSICAL RESTRAINT

Use: Physical restraint was used in the approved centre.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
1	General principles	X			
5	Orders	X			
6	Resident dignity and safety	X			
7	Ending physical restraint	X			
8	Recording use of physical restraint	X			
9	Clinical governance		X		
10	Staff training				X
11	Child residents	NOT APPLICABLE			

Justification for this rating:

There had been one episode of physical restraint in 2012 to the date of inspection. The clinical file of this resident and the Clinical Practice Form book were examined. The quality of documentation in the clinical file in relation to the episode of physical restraint was of a high standard. The Clinical Practice Form book had been completed satisfactorily. The policy on physical restraint, that was made available to inspectors, was out of date. Staff had not received training in relation to physical restraint. This had been a recommendation in the 2011 inspection report.

Breach: 9.2, 10.1

ADMISSION OF CHILDREN

Description: Children were not admitted to the approved centre.

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

Description: No death had been reported in 2012 to the date of inspection.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
2	Notification of deaths	NOT APPLICABLE			
3	Incident reporting	X			
4	Clinical governance (identified risk manager)		X		

Justification for this rating:

A record of incidents was examined by inspectors and was satisfactory. The approved centre forwarded a summary of all incidents to the Mental Health Commission as required under this Code of Practice. The risk management policy did not identify the risk manager as required by the Code of Practice on the Notification of Deaths and Incidents.

Breach: 4.2

Electroconvulsive Therapy (ECT) FOR VOLUNTARY PATIENTS

Use: ECT was not administered in the approved centre and no voluntary patient was in receipt of a programme of ECT at another location outside the approved centre.

ADMISSION, TRANSFER AND DISCHARGE

Part 2 Enabling Good Practice through Effective Governance

The following aspects were considered: 4. policies and protocols, 5. privacy confidentiality and consent, 6. staff roles and responsibility, 7. risk management, 8. information transfer, 9. staff information and training.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
	X		

Justification for this rating:

The approved centre had policies on admission, transfer and discharge, but no longer accepted people for admission. The service had developed a working relationship with some local nursing homes in view of the recent discharge of residents from St. Josephs' Hospital to nursing homes. The approved centre was not compliant with Article 32 in respect of Risk Management procedure and not all staff had received training in physical restraint.

Breach: 7.1, 9.3

Part 3 Admission Process

The following aspects were considered: 10. pre-admission process, 11. unplanned referral to an Approved Centre, 12. admission criteria, 13. decision to admit, 14. decision not to admit, 15. assessment following admission, 16. rights and information,17. individual care and treatment plan, 18. resident and family/carer/advocate involvement, 19. multidisciplinary team involvement, 20. key-worker, 21. collaboration with primary health care community mental health services, relevant outside agencies and information transfer, 22. record-keeping and documentation, 23. day of admission, 24. specific groups.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
NOT APPLICABLE			

Justification for this rating:

The approved centre no longer accepted people for admission.

Part 4 Transfer Process

The following aspects were considered: 25. Transfer criteria, 26. decision to transfer, 27. assessment before transfer, 28. resident involvement, 29. multidisciplinary team involvement, 30. communication between Approved Centre and receiving facility and information transfer, 31. record-keeping and documentation, 32. day of transfer.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
	X		

Justification for this rating:

One resident had been transferred to a general hospital and this was documented in the clinical file. However, no copy of the nurse transfer form or medical referral letter had been retained in the resident's clinical file.

Some residents of other wards in the approved centre had been transferred either to a nursing home or community residence; no clinical file was available for inspection.

Breach: 31.2

Part 5 Discharge Process

The following aspects were considered: 33. Decision to discharge, 34. discharge planning, 35. pre-discharge assessment, 36. multi-disciplinary team involvement, 37. key-worker, 38. collaboration with primary health care, community mental health services, relevant outside agencies and information transfer, 39. resident and family/carer/advocate involvement and information provision, 40. notice of discharge, 41. follow-up and aftercare, 42. record-keeping and documentation, 43. day of discharge, 44. specific groups.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
NOT APPLICABLE			

Justification for this rating:

No resident had been discharged from Aurora ward in the past year and no clinical file of a resident discharged was available for inspection against the Code of Practice.

Ten residents had been discharged from St. Joseph's since the inspection of 2011. The practice relating to discharge was for residents to be transferred to the alternative facility for a 'trial' period of approximately six weeks before being finally discharged.

HOW MENTAL HEALTH SERVICES SHOULD WORK WITH PEOPLE WITH AN INTELLECTUAL DISABILITY AND MENTAL ILLNESS

Description: Two residents were reported by staff to have a known intellectual disability and mental illness on Aurora ward.

The following aspects were considered: 5. policies, 6. education and training, 7. inter-agency collaboration, 8. individual care and treatment plan, 9.communication issues, 10. environmental considerations, 11. considering the use of restrictive practices, 12. main recommendations, 13. assessing capacity.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
			X

Justification for this rating:

No policy was in place and no education and training of staff of the approved centre had occurred to reflect the principles contained in this Code of Practice. Both residents had individual care plans, but only one had an individual care plan as described in the Regulations.

Breach: 5, 6, 8.

2.5 EVIDENCE OF COMPLIANCE WITH SECTIONS 60/61 MENTAL HEALTH ACT 2001 (MEDICATION)

SECTION 60 – ADMINISTRATION OF MEDICINE

Description: One involuntary patient had been detained for a period exceeding three months.

SECTION	FULLY COMPLIANT	NOT COMPLIANT
Section 60 (a)	**NOT APPLICABLE**	
Section 60 (b)(i)	**X**	
Section 60 (b)(ii)	**X**	

Justification for this rating:

The clinical file of this patient was examined by inspectors who found that the patient's rights under section 60 Mental Health Act 2001 had been satisfied.

SECTION 61 – TREATMENT OF CHILDREN WITH SECTION 25 MENTAL HEALTH ACT 2001 ORDER IN FORCE

Description: Children were not admitted to the approved centre so section 61 Mental Health Act 2001 did not apply.

SECTION THREE: OTHER ASPECTS OF THE APPROVED CENTRE

SERVICE USER INTERVIEWS

Two residents requested to speak to inspectors. Both were unhappy that the range of therapeutic services and programmes that had always been present up to “a month ago” were now absent since the retirement of the activation nurse. Both said they were bored. One was unable to go out unless accompanied by staff and because of shortages of staff on the ward on the day of inspection this could not be facilitated. Both talked highly of nursing staff. Both were unaware of their individual care plan or of where they were to go when Aurora ward closed. Remaining residents were greeted by inspectors during the course of this inspection.

OVERALL CONCLUSIONS

Aurora Ward was the last remaining ward in St. Joseph’s Hospital and was reported to be scheduled for closure later in 2012. The grubby and grimy condition of the kitchen and toilets was unhealthy for residents. A letter was sent to the proprietor of the approved centre seeking assurance that the kitchen and toilets had been deep cleaned. Assurances in writing, as well as photographs, were subsequently received by the Inspectorate from the approved centre. Two residents complained to inspectors about the lack of recreational and therapeutic activities and stated they were bored. Fire drills did not take place in the approved centre. Documentation of inspections relating to fire was requested by inspectors on the day of inspection but this was not forwarded to inspectors by the fourth day of the whole service evaluation. Documentation of inspections relating to fire was again requested by the Inspectorate subsequent to the inspection but this was not forwarded. In the clinical files examined only one resident had an individual care plan as described in the Regulations. One resident had not received a physical examination since June 2011. Training in physical restraint had not been provided to staff despite this being a recommendation in the 2011 Inspector of Mental Health Services Report.

RECOMMENDATIONS 2012

1. The hospital should close.

2. Fire drills must take place on a regular basis and evidence of such must be recorded.

3. The approved centre must be clean.

4. Each resident must have an individual care plan as described in the Regulations.

5. Therapeutic services and programmes must be available to each resident and in accordance with each resident’s individual care plan.

6. Each resident must have a physical examination at least every six months.

7. Written information on medications, including possible side-effects, must be available to residents.

8. The approved centre must be adequately staffed in order to ensure the provision of therapeutic services and programmes for each resident.

9. Clinical documentation must reflect risk assessment and risk management.

10. Training in physical restraint must be provided. This was a recommendation in the 2011 Inspector of Mental Health Services Report.

11. Medical staff should insert their medical council numbers after documenting clinical information in clinical files and on prescriptions.

12. All policies required by the Regulations must be current and available in the approved centre.