Report of the Inspector of Mental Health Services 2008

HSE AREA	Independent Sector
MENTAL HEALTH SERVICE	St. John of God Hospital Limited
APPROVED CENTRE	St. John of God Hospital
NUMBER OF UNITS OR WARDS	8
UNITS OR WARDS INSPECTED	St Peter's Carraig Dubh Ginesa
NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED	183
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	26 and 27 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. John of God Hospital was a not-for-profit independent teaching hospital. It had extensive private grounds that facilitated a range of outdoor recreational and sporting activities. Referrals to the hospital were received from all parts of the country and from the local Cluain Mhuire public adult mental health service.

The hospital had a number of specialty services including services related to alcohol and addiction, psychosis, eating disorders, psychiatry of later life and adolescent in-patient assessment and treatment.

At the time of the inspection, refurbishment work was under way in St. Peter's. Residents from St. Peter's and St. Paul's had been relocated for the duration of this work.

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	SPECIALTY
St Peter's located in St. Paul's	18	18	Acute admission
St Paul's located in St Mary's	24	Not inspected	
St Joseph's	32	Not inspected	
St Camillus's	27	Not inspected	
St Brigid's	20	Not inspected	
Carraigfergus	24	Not inspected	Psychiatry of later life
Carraig Dubh	16	16	Psychiatry of later life
Ginesa	12	13	Adolescent

The Inspectorate met with the director, the acting clinical director, the consultant psychiatrist from Ginsea Suite, the director of nursing, one of the assistant directors of nursing, the clinical nurse managers on the wards inspected, the principal clinical psychologist, the head of the occupational therapy department and a representative from the social work department.

It was evident to the Inspectorate that hospital staff were committed to engaging with the Inspectorate, the Mental Health Commission and other organisations such as the Healthcare Accreditation and Quality Unit – UK and the Quality Network for Inpatient Child and Adolescent Services, to work towards compliance with minimum statutory requirements and to ensure continuous quality improvement in the standard of care and treatment provided by the service. A project leader had been appointed to progress issues related to compliance and standards.

RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT

1. Multidisciplinary care plans should be introduced for each resident.

Outcome: The service established a working group to introduce multidisciplinary care plans in the hospital. A system was developed and was piloted by two teams from January until Mid April. The system has now been rolled out in all teams within the service and an audit was due to be completed in September 2008.

2. The management team should be enhanced by including heads of discipline in accordance with national policy.

Outcome: Heads of disciplines were not represented on the hospital management team. It was reported that the membership of the management team was determined by the Provincial Council as the governing authority of the St. John of God Hospital.

3. The needs of forensic patients should be addressed within an appropriate environment and treatment setting.

Outcome: It was reported that there were two residents with significant forensic histories who were inappropriately placed in the hospital. Referrals have been made to more appropriate settings and the outcome of assessments were not available on the day of inspection.

MDT CARE PLANS 2008

Individual care plans had been introduced for all admissions to the hospital a few weeks prior to the inspection. It was planned that residents who had been admitted prior to that would gradually move to the new care plans. The Inspectorate was informed that this would be completed within two months. The care plans contained detailed initial nursing and medical assessments, including risk assessment, that were completed on admission using standard forms. The Inspectorate welcomed the introduction of integrated clinical files, which were being used for recording interventions by all members of the resident's multidisciplinary team.

The Inspectorate discussed the care plan documentation and multidisciplinary team working with the service. The Inspectorate acknowledged that a significant amount of work had gone into the development and introduction of multidisciplinary individual care planning, which had only been recently introduced. However, the Inspectorate highlighted that there had been a statutory requirement for care plans to be in place for each resident since November 2006.

The Inspectorate highlighted a number of issues regarding the new care plans which led them to be non-compliant with the Regulations. This is discussed in more detail under Article 15 in this report. The service was given copies of a template used by the Inspectorate to review care plans, which may be of assistance to them in meeting compliance and in further enhancing the care plans.

The Inspectorate was of the view that the current care plan documentation did not do justice to the extent of multidisciplinary team work that was evident from reviewing the clinical files and from talking to the various professionals involved in providing care and treatment. In particular, there was no system for recording who attended the multidisciplinary team meetings, or the range of professionals who had contributed to the care plan.

At the time of inspection, most of the health and social care professionals were shared across general adult teams and specialty teams, creating some constraints in accessibility and ability to focus solely on development of speciality skills. The service was planning to continue to expand and develop speciality multidisciplinary services on the basis of gaps in national service provision. The service will need to ensure that the numbers and skill mix of staff continue to be appropriate to the needs of the residents as outlined in Article 26 (2) as the service expands and develops.

GOOD PRACTICE DEVELOPMENTS 2008

- A project leader had been appointed to take a lead role in ensuring compliance with the Mental Health Act and the various Rules, Regulations and Codes of Practice arising from it.
- Individual multidisciplinary care plans had been introduced and a standard format had been developed.
- Integrated clinical files had been introduced.

SERVICE USER INTERVIEWS

A group of the young people asked to meet with the Inspectorate. The general consensus was that they were satisfied with the care and treatment they were receiving and were involved in their treatment plans. They found some of the rules of the unit difficult at times but understood the need to have rules in place.

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

1. The individual care plans must be enhanced to ensure compliance with the Regulations [Article 15]. The care plans should document the extent of multidisciplinary team working that takes place within the service. The key worker role could be expanded to enhance the current care plan process, particularly in relation to documentation and evaluation of the care plan as discussed above.

2. The six-monthly physical reviews of residents must be completed [Article 19]. The Inspectorate recommended that the hospital put in place a system to ensure that these review dates are flagged, completed and documented.

3. Episodes of seclusion and physical restraint must be fully documented in residents' clinical files as set out in the relevant Rules and Codes of Practice. The Inspectorate noted that some services had developed a checklist to help ensure that all the requirements in relation to documentation were observed.

4. Information to residents should include provision of information on all multidisciplinary team members involved in their care and treatment, not just medical and nursing, routine verbal and written information about their diagnosis (unless there is a risk to the resident or other), and routine information on indications for use of all medications and possible side effects [Article 20]. The Inspectorate would expect that in circumstances where this was not done, the reason would be documented in the clinical file.

5. The hospital had introduced a bracelet for the identification of residents. Staff on St. Peter's reported that residents who were acutely ill or paranoid removed their own bracelets from time to time. The Inspectorate recommended that the practice of using identification bracelets on St. Peter's be reviewed, in light of the difficulties for some residents. A less intrusive system for identification of residents may be more suitable.

6. The management team should be enhanced to include heads of the health and social care professionals in line with *A Vision for Change*, the national mental health policy.

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 26/27 JUNE 2008

Article 4: Identification of Residents

The hospital had introduced a bracelet for the identification of residents. Staff on St. Peter's reported that residents who were acutely ill or paranoid removed their own bracelets from time to time. In Ginesa Suite, photographs of the young people were attached to their clinical files and the relevant prescription card index.

Compliant: Yes

Article 12 (1-4): Communication

A policy and procedure was in place regarding communication. Each resident in St. Peter's had access to mail and phone. The unit provided a public phone. Following the inspection, the approved centre submitted a policy that included a procedure for examining incoming and outgoing communication.

Compliant: Yes

Article 13: Searches

A policy and procedure was in place regarding searches. Following the inspection the approved centre submitted a policy that included a procedure for keeping a written record of searches including the reason for the search.

Compliant: Yes

Article 15: Individual Care Plan

Multidisciplinary care plans had been implemented a few weeks prior to the inspection. They included standard assessments by nursing and medical staff at admission, including risk assessment. About half the residents on St. Peter's had care plans completed; the other residents had separate nursing and medical care plans. In Ginesa Suite, all young people had multidisciplinary care plans that included their educational needs.

Each member of the team completed detailed and regular reviews and updates of care plans, which were stored in the clinical file. Young people contributed to their care plan by completing a standard evaluation form that

reviewed their perspective on their care and treatment. The care plans on Ginesa were comprehensive and detailed.

Breach: Not all the residents in the hospital had an individual care plan. Care plans did not comply with the Regulations [Article 3] as they did not document a set of goals for the resident, regular review and update by the multidisciplinary team, or consultation with the resident.

Compliant: No

Article 16: Therapeutic Services and Programmes

A range of individual and group therapeutic services were provided by the clinical psychology, social work, occupational therapy and pastoral care departments. Residents' progress was recorded in the integrated clinical file by all the professionals involved. Residents were directed to specific therapeutic interventions on the basis of need and this was discussed at the weekly multidisciplinary meetings that all team members attended. For residents on the new care plan, their therapeutic interventions were in accordance with their care plan.

Breach: Not all residents had the new individual care plans and therefore therapeutic programmes and services were not provided in accordance with the care plan as outlined in Article 16 (2).

Compliant: No

Article 17: Children's Education

Educational needs were assessed on Ginesa and included in the young person's care plan.

Compliant: Yes

Article 18: Transfer of Residents

The hospital was compliant with the requirements of this Article.

Compliant: Yes

Article 19 (1-2): General Health

Residents had access to general health services in the Blackrock Clinic or St. Vincent's Hospital by referral. There was evidence in the clinical files reviewed of reports from various medical consultants. Residents had access to the hospital's consultant physician if required. Residents had a physical examination at admission. There was no record that six-monthly physical examinations to assess general health needs had been completed in the clinical files reviewed on St. Peter's or Carraig Dubh. There was no system in place to ensure that general health needs were assessed every six months.

Breach: Six-monthly general health needs had not been assessed as outlined in Article 19 (1)(b).

Compliant: No

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

The residents' information booklet on St. Peter's Ward had been updated. Nursing staff reported that residents were not routinely given written information about their diagnosis and information about medication was made available only when the resident requested it.

Breach: Residents were not provided with verbal and written information on their diagnosis (unless considered a risk) or information about their medications, including any possible side effects as outlined in Article 20 (1)(c) and Article 20 (1)(e).

Compliant: No

Article 21: Privacy

The hospital was compliant with this Article.

Compliant: Yes

Article 22: Premises

Overall, the hospital was clean, well decorated and comfortable, with many amenities for residents. Work on the redesign of St. Peter's had commenced. St. Peter's and St. Paul's had been relocated for the duration of the building work.

Compliant: Yes

Article 26: Staffing

The hospital was compliant with this requirement. All multidisciplinary teams had a complement of health and social care professionals attached, although these were often shared across teams and were not solely dedicated to specialty areas.

Compliant: Yes

Article 27: Maintenance of Records

The hospital was compliant with this Article.

Compliant: Yes

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

SECLUSION

Seclusion was used only on St. Peter's. However due to the building work on St. Peter's the ward was temporarily located on St. Paul's where there was temporary seclusion facilities, which were satisfactory. Previous inspections reported that the design and decor of the seclusion room and area were not of good standard. The Inspectorate were shown the new seclusion suite in the revamped ward which was a significant improvement.

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

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Orders**	Non-compliant [Section 2 .1, Section 2 .9, Section 2 .10]
3	**Patients' dignity and safety**	Compliant
4	**Monitoring of the patient**	Non-compliant [Section 4.6]
5	**Renewal of seclusion orders**	Compliant
6	**Ending seclusion**	Compliant
7	**Facilities**	Compliant
8	**Recording**	Non-compliant [Section 8.1]
9	**Clinical governance**	Non Compliant [Section 9.2]
10	**Staff training**	Compliant
11	**CCTV**	Compliant
12	**Child patients**	Not applicable

Breach: The seclusion register did not indicate an immediate threat of harm to self or others or that all alternatives had been considered [Section 2.1]. No evidence was found in the clinical file that the patient was informed of the reasons for and likely duration of seclusion or that there was reason not to inform the patient [Section 2.9]. No record was found in the clinical file to indicate what had occurred in relation to communication with next of kin [Section 2.10].

Use of seclusion was not recorded in the clinical files reviewed on St. Peter's, although recorded in the seclusion register [Section 8.1]. No documentation was found in the clinical files reviewed that the episodes of seclusion had been discussed at multidisciplinary team meetings within two working days of the incident [Section 9.2].

Compliant: No

ECT

There was a temporary ECT suite while work was being completed on the new suite on St. Paul's. A new ECT machine had been purchased.

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**	ECT had not been administered during pregnancy.

Compliant: Yes

MECHANICAL RESTRAINT

The service had a policy stating that mechanical restraint was not used within the hospital. Two of the psychiatry of later life wards, Carraigfergus and Carraig Dubh, were visited during the inspection. There was no evidence that mechanical restraint was being used on either ward. There was no evidence either of the use of mechanical restraint for enduring self-harm behaviour.

Compliant: Not applicable

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

PHYSICAL RESTRAINT

The recording of physical restraint was reviewed on St. Peter's. The hospital had a written policy and all staff received training in relation to physical restraint. Training records were kept by the ward manager.

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

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	**Orders**	Non-compliant [Section 2.1, Section 2.7, Section 2.9, Section 2.10]
3	**Resident dignity and safety**	Compliant
4	**Ending physical restraint**	Compliant
5	**Recording use of physical restraint**	Non-compliant [Section 5.1]
6	**Clinical governance**	Non-compliant [Section 6.2]
7	**Staff training**	Compliant
8	**Child residents**	Compliant

Breach: The physical restraint register did not indicate an immediate threat of harm to self or others or that all alternatives had been considered [Section 2.1]. There was no record in the clinical file that the registered medical practitioner had informed the consultant psychiatrist [Section 2 .7]. There was no evidence in the clinical file that the resident was informed of the reasons for and likely duration of physical restraint or that there was reason not to inform the patient [Section 2.9]. There was no record in the clinical file to indicate what had occurred in relation to communication with next of kin [Section 2.10].

Use of physical restraint was not recorded in the clinical files reviewed on St. Peter’s and Carraig Dubh, although recorded in the physical restraint register [Section 5.1]. There was no documentation in the clinical files reviewed that the episodes of physical restraint had been discussed at multidisciplinary team meetings within two working days of the incident [Section 6.2].

Compliant: No

ADMISSION OF CHILDREN

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**	Compliant
3	**Treatment**	Compliant
4	**Leave provisions**	Compliant

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**	ECT had not been administered during pregnancy.

Compliant: Yes

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

The hospital was compliant with the requirements of Section 60. Section 61 was not applicable.

Compliant: Yes