Report of the Inspector of Mental Health Services 2011

EXECUTIVE CATCHMENT AREA	Limerick, North Tipperary, Clare
HSE AREA	West
MENTAL HEALTH SERVICE	Limerick
APPROVED CENTRE	St. Joseph's Hospital
NUMBER OF WARDS	2
NAMES OF UNITS OR WARDS INSPECTED	Aurora St. Mary's
TOTAL NUMBER OF BEDS	28
CONDITIONS ATTACHED TO REGISTRATION	No
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	26 July 2011

OVERVIEW

In 2011, the Inspectorate inspected this Approved Centre against all of the Mental Health Act 2001 (Approved Centres) Regulations 2006, the Rules and Codes of Practice.

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 2010. In addition to the core inspection process, information was gathered from service user interviews, staff interviews and photographic evidence collected on the day of the inspection.

DESCRIPTION

St. Joseph's Hospital, a large grey-fronted building, which opened in 1825, was located in Limerick city. At the last inspection in October 2010, there were 54 beds and four wards. Since then two wards had been closed, St. Rita's in February 2011 and St. Brendan's in April 2011. This had been achieved by discharging residents to nursing homes and supported accommodation in the community. Two wards remained open, St Mary's and Aurora, providing a total of 28 beds. No further admissions were being made to St. Joseph's Hospital. On the day of inspection two persons were detained under the Mental Health Act 2001.

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

COMPLIANCE RATING	2009	2010	2011
Fully Compliant	22	25	20
Substantial Compliance	1	0	1
Minimal Compliance	2	1	5
Not Compliant	4	3	3
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	18	18	Rehabilitation and General adult
St. Mary's	10	8	General adult

QUALITY INITIATIVES

- Two wards had closed and residents were discharged to accommodation in the community.

PROGRESS ON RECOMMENDATIONS IN THE 2010 APPROVED CENTRE REPORT

1. An urgent review of medication should take place in all units in the hospital.

Outcome: The Inspectorate was informed that this had been completed and a copy of this review was received.

2. Individual care plans, as defined in the Regulations, must be introduced.

Outcome: While all residents had individual care plans, these did not meet the requirements of the Regulations.

3. All residents must have regular six-monthly physical health reviews.

Outcome: All residents had six-monthly physical health reviews completed. Both wards had a system in place to track when these were due to be done.

4. The service should work to develop policies and practices relevant to the Codes of Practice relating to Admission, Transfer and Discharge to and from an Approved Centre and Persons working in Mental Health Services with People with an Intellectual Disability.

Outcome: The service had policies relating to the Code of Practice on Admission, Transfer and Discharge and it was developing policies and practices with regard to working with people with an intellectual disability and mental illness.

5. All teams must be staffed in accordance with *A Vision for Change* recommendations.

Outcome: The mix of staff on the teams had improved but there continued to be gaps in health and social care professionals on the teams.

6. St. Joseph's hospital was unsuitable for the purpose of providing care and treatment to residents and should close.

Outcome: St. Joseph's remained an unsuitable facility for providing care and treatment to residents. Two wards had been closed and the bed numbers had been reduced substantially. Further work was needed to close the remaining wards.

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	2009	2010	2011
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:

Photographs of residents were used for the purposes of identification. These were stored in their respective clinical files.

Article 5: Food and Nutrition

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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:

Water coolers were provided on each ward. A choice of options for mealtimes was provided. Special diets were catered for. On St. Mary's ward the residents who experienced swallowing problems had been assessed by a clinical speech and language therapist and their resulting dietary requirements had been incorporated into their respective care plans.

Article 6 (1-2): Food Safety

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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 service had up-to-date food inspection and environmental health officer's reports and there was a record of active engagement and compliance with recommendations from these reports.

Article 7: Clothing

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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:

Each resident had their own individual supply of clothing, kept in separate wardrobes. None of the residents were in night clothes during the inspection. The approved centre provided a novel high street clothes shop on the main hospital corridor entitled “creative boutique” where residents could purchase clothes. This shop was staffed by two personnel and staff reported that residents often returned post discharge from community residences to buy clothing there.

Article 8: Residents' Personal Property and Possessions

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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 policies and procedures relating to residents' personal property and possessions. A property book was maintained and signed by the resident and staff. Each resident had their own locker and wardrobe for keeping their possessions. The hospital provided for the safe-keeping of personal property.

Article 9: Recreational Activities

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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:

A range of recreational activities was made available on the wards and there was access to a recreational and activity centre on the grounds of the hospital. Trips were organised to places of interest and most residents were provided with opportunities to go on holidays.

Article 10: Religion

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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 could go to local places of worship and the hospital had a chaplain who visited the wards.

Article 11 (1-6): Visits

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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 a policy and procedures for visiting. Visiting areas were available and visiting times were flexible.

Article 12 (1-4): Communication

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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 had access to their post and some had their own mobile phones. Hands-free phones were available on the wards for use by residents. The approved centre had a policy and procedures relating to communication.

Article 13: Searches

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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 policies and procedures relating to searches which included searching with and without consent. Searches were always carried out by two nurses and documented. Two residents in St. Mary's ward had been searched on a number of occasions and their individual clinical files were inspected and met the requirements of the Regulations.

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

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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 policies and protocols for care of residents who are dying. The Mental Health Commission had been notified of deaths that had occurred during the year.

Article 15: Individual Care Plan

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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:

All individual clinical files inspected contained an individual care plan (ICP), however, the ICPs did not adequately meet the requirements of the Regulations. The ICPs did not reflect multidisciplinary team (MDT) input and review, and did not identify the resources and interventions required to meet individual needs.

The purported MDT ICPs were more reflective of the nursing care plans and drew significantly from the CASIG (Client's Assessment of Strengths, Interests and Goals) care plan tool which nursing staff had implemented. The MDT ICP was filled out by nursing staff. The only evident MDT input was a record of who had attended the review meeting. The CASIG had been completed and regularly reviewed and recorded for all residents. Understandably, the domains of care identified and provided for reflected nursing expertise. There was little evidence of other needs being addressed or of medical or health and social care professionals input into the individual care plan.

Breach: 15

Article 16: Therapeutic Services and Programmes

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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 programme provision was not sufficiently linked, or specified in ICPs and therefore, the approved centre did not meet the requirements of Article 16.

There was little evidence in the clinical files reviewed on St. Mary's and Aurora wards that a range of therapeutic activities and programmes was provided to residents or that therapeutic activities were directed at restoring or maintaining optimal levels of physical and psychosocial functioning. The individual clinical files inspected recorded occasional input from the community care teams, including, clinical speech and language therapy, physiotherapy, occupational therapy and chiropody. Whilst this was good practice and to be welcomed, it was not evident that there was ongoing therapeutic provision to support optimal functioning.

Breach: 16(1), (2)

Article 17: Children's Education

The approved centre did not admit children.

Article 18: Transfer of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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:

The approved centre had up-to-date policies and procedures for the transfer of residents. A nursing form was completed and accompanied any residents being transferred. The individual clinical files of two residents who had been transferred were inspected and did not contain a copy of any medical summary report for the purpose of transfer of care. The approved centre advised that they subsequently filed transfer letters into individual clinical files.

Breach: 18(1)

Article 19 (1-2): General Health

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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:

All residents whose clinical files were reviewed had six-monthly general health reviews completed. The approved centre had a system in place to track when physical and psychiatric reviews were completed and when the next ones were due. Residents had access to national screening programmes as appropriate.

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

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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:

There was no evidence that residents were provided with details of their multidisciplinary team. There was no evidence that written or verbal information on diagnosis or medication including side-effects was provided. Inspectors were informed that an information leaflet which detailed housekeeping practices, arrangements for visiting, personal property and mealtimes, however, this was not available on the day of inspection.

Breach: 20 (a), (c), (e)

Article 21: Privacy

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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:

Each resident's bed had a curtain that could be pulled for privacy.

Article 22: Premises

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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 two wards were bright and clean. Efforts had been made to upgrade furnishings and decor, however, the building was unsuitable for the purpose of providing care and treatment to residents. The two wards were clean and bright, however, the male lavatories smelt strongly of urine owing to the fabric of the building. Upstairs was not wheelchair accessible.

Breach: 22 (3)

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

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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 up-to-date policies regarding the ordering, prescribing, storing and administration of medication.

Article 24 (1-2): Health and Safety

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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 up-to-date policies and procedures relating to the health and safety of residents, staff and visitors.

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
St. Mary's	CNM RPNs	1 2	2
Aurora	CNM1/2 RPN	1 3	0 2

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Non Consultant Hospital Doctor (NCHD).

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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 HSE policies on the recruitment, selection and vetting of staff were applied in the approved centre.

There was little evidence of multidisciplinary team input and an adequate skills mix for the assessed needs of residents on Aurora ward.

Staff training in the application of physical restraint had not been updated since 2008.

Breach: 26

Article 27: Maintenance of Records

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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:

The individual clinical files inspected were not kept in good order as the identity of the signatory was illegible in many records entered in the individual clinical files. Medical staff did not enter their medical council number (MCN) when making entries. In many instances the medication prescription signature was illegible and did not contain a MCN. The approved centre subsequently advised that a central bank of signatures of all NCHDs was held and updated every six months. The inspectors asked ward staff on the day of inspection if they could identify the signatories in a couple of instances and they were unable to do so.

The individual clinical files inspected on St. Mary's ward contained clinical data and financial account statements interspersed in the front section of the clinical files. Inspectors requested that the financial information be filed as a separate record.

Documentation of inspections relating to food safety and health and safety were maintained. HSE policies were in place relating to the creation of, access to, retention of and destruction of records.

Breach: 27(1)

Article 28: Register of Residents

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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:

An up-to-date register of residents was maintained and made available to the Inspectorate.

Article 29: Operating policies and procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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 operated under policies for the Mid West integrated service area and also had a number of specific policies localised for the approved centre. There was a system in place for reviewing the integrated service area policies every two years. Policies were available to staff via the internet and hard copies were also provided on each ward. In the policy folders there was space for staff to sign to indicate they had read and understood the policies and this had been completed.

Article 30: Mental Health Tribunals

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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 were two detained patients who had been facilitated to attend tribunals.

Article 31: Complaint Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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:

A record of complaints related to the approved centre was not provided to the Inspectorate, thus there was no evidence that complaints were investigated promptly or that a record of complaints was maintained. The inspectorate subsequently wrote and requested a copy of the complaints log and this was not made available. The Irish Advocacy Network advocate had reported in 2010 that a number of complaints made to staff in St. Joseph's Hospital had not been adequately responded to by the approved centre.

The inspectorate requested that the approved centre indicate whether the complaints officer was based within the approved centre. The approved centre did not provide this information.

The complaints procedure was displayed in the approved centre.

Breach: 31(4), (5), (6), (7).

Article 32: Risk Management Procedures

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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 risk management policy in place. Arrangements were in place for responding to emergencies and for the protection of children and vulnerable adults from abuse.

The risk management policy was not fully operational, in that, individual clinical files inspected did not record risk assessment. Risk assessment should be implemented and updated to support successful care, and discharge or transfer of residents. In one individual clinical file inspected, the last recorded psychiatric review was approximately eight months previously. The Inspectorate drew this to the attention of clinical staff who undertook to ensure a review would be carried out promptly.

Breach: 32(1)

Article 33: Insurance

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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.

Article 34: Certificate of Registration

LEVEL OF COMPLIANCE	DESCRIPTION	2009	2010	2011
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 current certificate of registration was displayed prominently 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.

ECT (DETAINED PATIENTS)

Use: ECT was not administered in the approved centre. No patients were receiving ECT in another centre.

MECHANICAL RESTRAINT

Use: Mechanical restraint was not used in the approved centre. Mechanical restraint under Part 5 of the Rules was used on St. Mary's ward and three individual clinical charts were reviewed.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
1	General principles	NOT APPLICABLE			
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	NOT APPLICABLE			
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	X			

Justification for this rating:

The use of lap belts had been prescribed by the treating consultant and were reviewed and documented in a timely way in the three individual clinical files.

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

PHYSICAL RESTRAINT

Use: The Physical Restraint Clinical Practice Form books on St. Mary's and Aurora wards were inspected. No physical restraint episodes had been documented on St Mary's ward. There had been two episodes of physical restraint on Aurora ward.

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:

Most of the nursing staff group in St. Joseph's did not have training in physical restraint. There was no record available to the Inspectorate concerning training for other disciplines. The service had its own trainers and informed the Inspectorate that training in physical restraint had been prioritised for the acute unit in Limerick and would be rolled out across the service over time. Staff reported that training in physical restraint techniques had not been updated since 2008. The approved centre had a policy on the use of physical restraint, including training, but did not update training according to its own policy.

Breach: 10.1

ADMISSION OF CHILDREN

Description: The approved centre did not admit children.

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

Description: At the time of inspection two deaths had occurred in 2011 in the approved centre.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
2	Notification of deaths	X			
3	Incident reporting		X		
4	Clinical governance	X			

Justification for this rating:

The deaths that had occurred had been notified to the Mental Health Commission. A record of adverse incidents was kept. The risk management policy had not been implemented in relation to clinical risk assessments which had not been completed for a number of residents.

Breach: 3.1 (1), (2)

ECT FOR VOLUNTARY PATIENTS

Use: ECT was not used in the approved centre and no resident was receiving ECT in another facility.

ADMISSION, TRANSFER AND DISCHARGE

Description: At the time of inspection there had been no admission to the approved centre in 2011. The Inspectorate were informed that, consistent with closure plans for the remaining wards, the approved centre no longer admitted residents. The approved centre discharged and transferred residents.

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 risk management policy was not fully implemented. There was no evident risk assessment in the clinical files inspected. Staff training had not been up dated in respect to physical restraint. Discussion with staff highlighted a lack of clarity in distinguishing transfer from discharge. Inspection of individual clinical files of some individuals perceived by staff to have been transferred, recorded the resident as discharged. Staff training in this regard needed to be updated.

Breach: 7.1, 9.1, 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 had ceased admissions.

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:

A number of residents had been transferred to community residences during the year. Staff identified several individuals who had been transferred to another facility and inspectors examined a number of individual clinical files. It was apparent that there was some confusion or lack of clarity in the records, as some files recorded “discharged” when the intent had been to transfer on a trial basis. The resident’s and family’s involvement in the transfer process was not always recorded.

Risk assessment and management plan were not being reviewed or recorded prior to transfer. One individual who had been transferred to a 24-hour nursing staffed community residence had quickly reverted to a risk behaviour pattern and had been transferred back into St. Joseph’s Hospital.

Breach: 27.1, 31.3

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
			X

Justification for this rating:

A significant number of residents had been discharged from the approved centre to nursing homes and a range of community residences since last year's inspection. In that context, it was alarming to note, that in the five individual clinical files reviewed of recent discharges there was no documentation relating to discharge by the consultant psychiatrist responsible for the care and treatment of these residents. Nursing staff had completed a discharge/transfer form which was stored in the clinical chart and it was not evident on the form whether the resident had been discharged or transferred. The form was not addressed to anyone so it was not evident if any written information was sent to the receiving facility about the resident. There was no evidence of pre-discharge assessments having been completed. The clinical files did not document the consultant psychiatrist's decision to discharge the resident or the multidisciplinary team involvement in this. There was no record of advance planning or preparation of residents or the families and carers. Staff reported that nursing staff had been active facilitators in the discharge process and had liaised with other facilities and with families, however, this was not recorded in the individual clinical file. Follow-up and after-care provided by nursing staff was well documented.

Breach: 33, 34, 35, 36, 37.3, 38, 39, 41, 42.

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

Description: Two residents had an intellectual disability.

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:

There was no policy in place on the management of individuals with intellectual disability and mental illness and the relevant staff training had not been completed. Both residents who had an intellectual disability had individual care plans in place.

Breach: 5, 6.1, 6.2

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

SECTION 60 – ADMINISTRATION OF MEDICINE

Description: Two patients had been detained for approximately three months.

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

Justification for this rating:

The individual clinical files were inspected. Written consent for the continued administration of medication was recorded.

SECTION 61 – TREATMENT OF CHILDREN WITH SECTION 25 ORDER IN FORCE

Description: Children were not admitted to the approved centre.

SECTION THREE: OTHER ASPECTS OF THE APPROVED CENTRE

SERVICE USER INTERVIEWS

Residents were greeted by inspectors throughout the course of the inspection. Two residents spoke with inspectors and expressed a desire to move out of the hospital into supported community living.

OVERALL CONCLUSIONS

Clinical staff's practice in relation to recording discharge or transfer documentation was poor and ambiguous. Despite this, staff and residents were to be commended on the successful transfer and discharge of many residents to community accommodation during the year. Two nursing staff had been assigned to liaise with families and with community agencies in facilitating this process, both for the purpose of providing a more suitable care setting and also to enable the closure of wards in St. Joseph's Hospital. The Inspectorate recommended that: the clinical notes and correspondence related to this be included in the individual clinical files and not in separate off-site nursing notes; the medical records should accurately record the decision to discharge or transfer and should record what clinical information was provided to the receiving community residence, nursing home or primary care centre.

As noted in previous inspection reports, the premises did not provide a therapeutic environment, was wholly unsuited to 21st century mental health care and should be closed.

Nursing staff had completed a care and rehabilitation needs assessment in conjunction with each individual resident and delivered nursing care to meet identified needs. There was little or no recorded input from health and social care professionals other than attendance at review meetings. Thus, optimal psychosocial care was not being provided to residents.

RECOMMENDATIONS 2011

1. The hospital should close.

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

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

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

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

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

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

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

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