Acute Psychiatric Unit 5B, University Hospital Limerick

ID Number: AC0002

2017 Approved Centre Focused Inspection Report (Mental Health Act 2001)

Acute Psychiatric Unit 5B
University Hospital Limerick
Dooradoyle
Limerick

Approved Centre Type:
Acute Adult Mental Health Care

Most Recent Registration Date:
1 March 2015

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mark Sparling

Inspection Team:
Noeleen Byrne, Lead Inspector
Siobhán Dinan
Donal O'Gorman

Inspection Date:
24 January 2017

Inspection Type:
Focused Inspection

Previous Inspection Date:
22 – 25 November 2016

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
24 August 2017

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1.0 Focused Inspection Process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

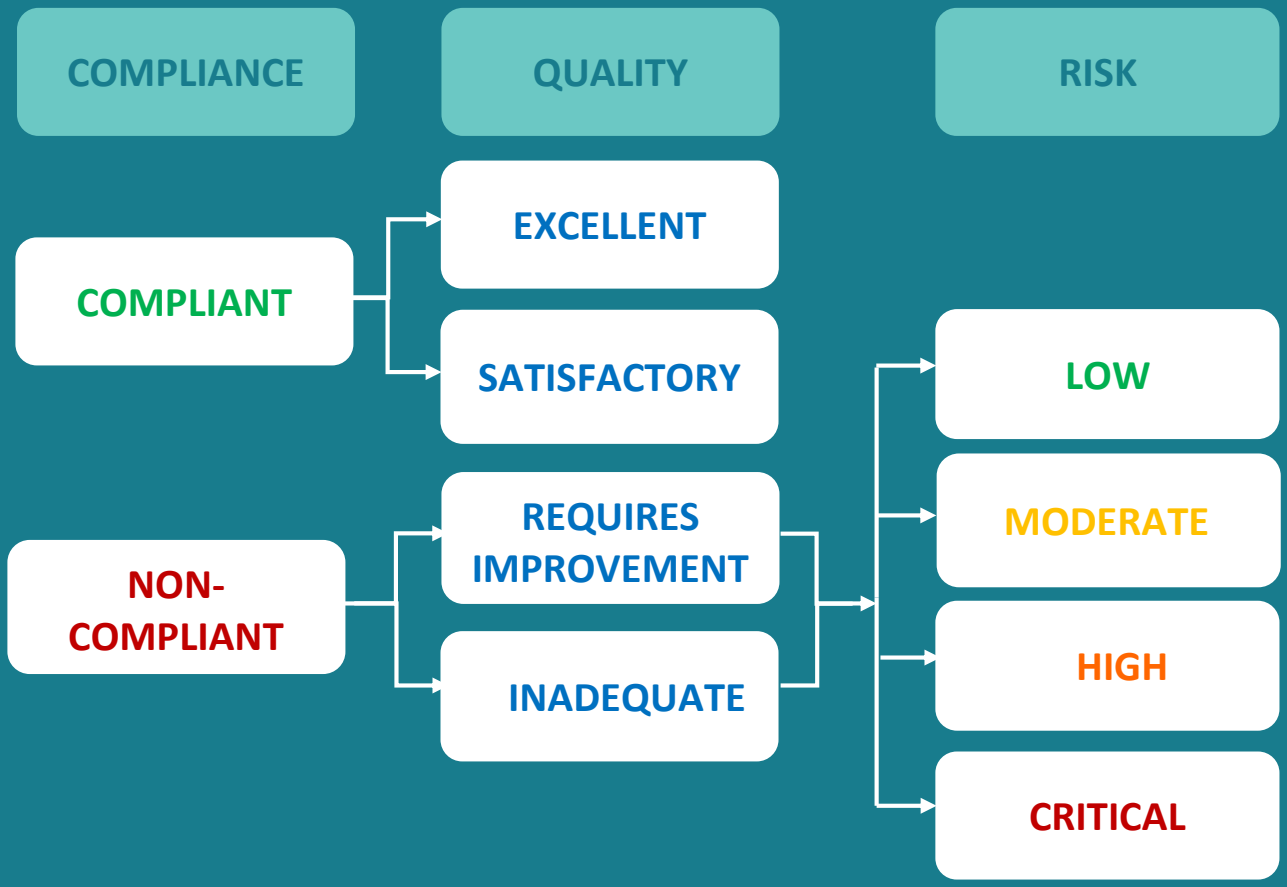
The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres.

In addition to the principal function of the Inspector of Mental Health Services under Section 51 of the Mental Health Act 2001 to inspect every approved centre at least once a year (and other mental health services, as appropriate), the Inspector may also undertake a focused inspection.

During a focused inspection, the Inspector may visit and inspect any premises where mental health services are provided and make a report in writing to the Commission to ascertain whether or not due regard is being had to the Mental Health Act 2001 and its provisions.

COMPLIANCE, QUALITY AND RISK RATINGS

The following ratings are assigned to areas inspected. COMPLIANCE RATINGS are given for all areas inspected. QUALITY RATINGS are given for all regulations, except for 28, 33 and 34. RISK RATINGS are given for any area that is deemed non-compliant.



2.0 Focused Inspection – Acute Psychiatric Unit 5B, University Hospital Limerick

2.1. Scope of focused inspection

This unannounced focused inspection was a follow-up to the 2016 annual inspection. Three regulations were inspected against:

- Regulation 21: Privacy
- Regulation 22: Premises
- Regulation 32: Risk Management Procedures

The 2016 inspection identified the following areas of concern.

Regulation	Risk Rating	Reasons for Non-Compliance
Regulation 21: Privacy	Critical	• Bed screening was inadequate and did not ensure privacy. • The PA system was loud and intrusive. • Residents' phone conversations could be overheard because the phone was located in a communal area and did not have a privacy hood.
Regulation 22: Premises	Critical	• The premises were not clean or maintained in good structural and decorative condition. • The premises were not properly ventilated. • The condition of the physical structure and the overall approved centre environment were not maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff, and visitors.
Regulation 32: Risk Management Procedures	High	• The risk management policy was not comprehensive, as required by part 1 of the regulation. • The risk management policy was not implemented. • The policy did not reference the identification and assessment of risks throughout the approved centre.

These areas of non-compliance were referred to the Mental Health Commission's Regulatory Review Committee. An immediate action notice was issued to the registered proprietor, and an action plan to correct the areas of non-compliance was requested.

2.2 Introduction to the approved centre

Unit 5B, an acute psychiatric unit, was the approved centre for Limerick Mental Health Services. It was situated on the ground floor of University Hospital Limerick in Dooradoyle. Access to the approved centre was through the main hospital and via a separate dedicated entrance. The approved centre was registered for 50 beds. At the time of the inspection, 42 beds, or fewer, were in use because the high observation area had not been opened.

2.3. Governance

The approved centre was governed by the Limerick Mental Health Services management team, who met in December 2016 and considered the findings of the Mental Health Commission (MHC) inspection of November 2016. The Quality, Risk, and Patient Safety Committee met on four occasions in 2016. The risk register escalation algorithm was updated by management and a copy of this document was forwarded to the MHC. The risk from smoking in the approved centre had not been addressed under the governance structures.

Management of the approved centre agreed to complete audits on hygiene and cleanliness more frequently, and the supervisor of the contract cleaning company agreed to attend the centre three times daily. A redevelopment group was formed to oversee the building and development of the centre and was monitoring the programme of works.

3.0 Findings

3.1. Summary of findings from the focused inspection

Regulation	Findings	Risk Rating
Regulation 21: Privacy	Non-Compliant	Critical
Regulation 22: Premises	Non-Compliant	Critical
Regulation 32: Risk Management Procedures	Non-Compliant	High

3.2. Resident interviews

Residents were invited to speak with the inspection team, and nine residents of the approved centre agreed to do so. One resident who was preparing for discharge was very complimentary about the staff and grateful for all they had done during the resident's stay in hospital. Another resident was a new admission and was not happy with the cleanliness of the premises. One of the residents said that the unit was often untidy.

All residents reported that they had access to sufficient activities during the day, including a gymnasium, a beauty therapy room, and a range of books and DVDs. Two residents said they did not have access to outdoor activities and one requested an outdoor smoking shelter.

The spouse of one resident met with the inspection team and said that staff were very understanding and had helped them to understand the medical terminology, the medication, and the programme of therapeutic services recommended.

3.3. Inspection Findings and Required Actions – Regulations

Regulation 21: Privacy

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating CRITICAL

The registered proprietor shall ensure that the resident's privacy and dignity is appropriately respected at all times.

INSPECTION FINDINGS

Processes: The approved centre did not have a written policy in relation to resident privacy.

Training and Education*:* Relevant staff interviewed were able to articulate the processes for ensuring resident privacy and dignity in the approved centre.

Monitoring: An annual review had not been undertaken to ensure that the premises and facilities were conducive to resident privacy. No analysis had been completed to identify opportunities to improve the processes relating to resident privacy and dignity.

Evidence of Implementation*:* The general demeanour of staff in their dealings with residents was appropriate. Residents were called by their preferred names, and staff were respectful and mindful of residents' privacy and dignity. Staff spoke to residents in a calm, pleasant, and courteous manner, and they addressed matters relating to care and treatment in a private and confidential way. Clinical staff were observed to knock on residents' bedroom doors before entering. Residents were dressed in day clothes during the inspection. Bathrooms, showers, and toilet doors had locks with an override function.

Staff used a PA system to call residents to therapy groups and for the dispensing of medication. The system was also used to alert staff that they were needed at the nurses' station. The system was very loud and intrusive and not conducive to resident privacy and dignity.

Four bedrooms did not have adequate screening or privacy curtains to ensure residents' privacy and dignity. One of the four-bed rooms had been converted into a five-bed room without adequate screening for the additional resident.

At the time of the 2016 inspection, the communal TV lounge in the Psychiatry of Later Life area had not opened because the locks on the doors into the garden were faulty. During the focused inspection, it was observed that this room was being used as a bedroom. Following a request by the inspectors, staff replaced two privacy curtains and made arrangements for an outside contractor to install two more.

Residents could use the office telephone, which was not portable. The handset was passed to the resident through a Perspex panel, meaning that conversations were held in public and could be overheard.

The approved centre remained non-compliant with this regulation for the following reasons:

a) **Bed screening was inadequate and did not ensure privacy.**
b) **The PA system was loud and intrusive and not conducive to resident privacy and dignity.**
c) **Residents' phone conversations could be overhead because the phone was in a communal area and did not have a privacy hood.**
d) **A room designated as a TV lounge was being used as a bedroom for one resident.**

During the 2016 Mental Health Commission inspection, the approved centre was found non-compliant with this regulation for the reasons listed at a), b), and c) above. During the focused inspection, an additional reason for non-compliance was identified: A designated communal TV lounge was being used as a bedroom.

Regulation 22: Premises

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating CRITICAL

(1) The registered proprietor shall ensure that:

(a) premises are clean and maintained in good structural and decorative condition;

(b) premises are adequately lit, heated and ventilated;

(c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

(2) The registered proprietor shall ensure that an approved centre has adequate and suitable furnishings having regard to the number and mix of residents in the approved centre.

(3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff and visitors.

(4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose in so far as it practicable and in accordance with best contemporary practice.

(5) Any approved centre in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall ensure that the buildings are, as far as practicable, accessible to persons with disabilities.

(6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and 2001, Part M of the Building Regulations 1997, the Disability Act 2005 and the Planning and Development Act 2000.

INSPECTION FINDINGS

Processes: The approved centre did not have a written policy in relation to its premises. The inspection team was presented with the draft version of a new policy. The draft document included requirements of the *Judgement Support Framework*, with the exception of details of the following:

- The infection control programme.
- The utility controls and requirements.
- The process for identifying hazards and ligature points.

Training and Education: Relevant staff interviewed could articulate the processes relating to the maintenance of the premises, as set out in the draft policy.

Monitoring: There was documentary evidence that a hygiene and infection control audit and a ligature audit had been undertaken. Analysis was completed to identify opportunities to improve the premises. This was documented.

Evidence of Implementation: Residents had access to personal space throughout the unit, including a large and bright sitting room, a dining area, an activity room, a beauty room, an art room, a multi-sensory room, and a communal seating area. They also had access to sufficient spaces for moving about, including outdoor spaces. Rooms were adequately heated, and radiators had safety covers. Lighting in communal rooms was adaptable and suited the needs of residents and staff. Appropriate signage and sensory aids were in place to support resident orientation.

Not all rooms in the approved centre were well ventilated, and private and communal areas were not shielded from excessive noise: The PA system was used frequently and was loud and intrusive.

The approved centre was not maintained in a good state of repair, externally and internally, and cracked glass was observed on three doors. A programme of general maintenance, decorative maintenance, and cleaning was in place, and records of these were retained in an online system. Ligature points had been minimised throughout the approved centre, but other hazards had not been addressed, including trip and spillage hazards.

Although a cleaning schedule was implemented, the approved centre was not clean, hygienic, and free from offensive odours. In the male and female accommodation and in the Psychiatry of Later Life area, bins were overflowing with rubbish and floors were dirty. In one of the male dormitories, there were cigarette butts and burns on the floor, radiator, table, and windowsill. Cigarette butts were observed on the floor of the sitting room, which also smelled of smoke, indicating that residents were smoking indoors. The linen room was not adequately ventilated and smelled malodorous.

Each resident was provided with a wardrobe and locker in which to store their clothes and belongings. The wardrobes were fitted with specially designed anti-ligature rails, but they collapsed when clothes hangers were placed on them, which prevented residents from hanging up their clothes.

There was a sufficient number of toilet and bathroom facilities in the approved centre, and toilets were accessible and situated close to day and dining areas. There were dedicated sluice, cleaning, and laundry rooms.

The approved centre remained non-compliant with the regulation for the following reasons:

- **(a) The premises were not clean or maintained in good structural and decorative condition, 22(1)(a).**
- **(b) The premises were not adequately ventilated, 22(1)(b).**
- **(c) The condition of the physical structure and the overall approved centre environment was not developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff, and visitors, 22(3).**
- **(d) Suitable furnishings were not provided in the approved centre, 22(2).**

During the 2016 Mental Health Commission inspection, the approved centre was found non-compliant with this regulation for the reasons listed at a), b), and c) above. During the focused inspection, an additional reason for non-compliance was identified: The rails in the wardrobes were unsuitable because they collapsed when clothes hangers were placed on them.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating High

(1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:

(a) The identification and assessment of risks throughout the approved centre;

(b) The precautions in place to control the risks identified;

(c) The precautions in place to control the following specified risks:

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;

(e) Arrangements for responding to emergencies;

(f) Arrangements for the protection of children and vulnerable adults from abuse.

(3) The registered proprietor shall ensure that an approved centre shall maintain a record of all incidents and notify the Mental Health Commission of incidents occurring in the approved centre with due regard to any relevant codes of practice issued by the Mental Health Commission from time to time which have been notified to the approved centre.

INSPECTION FINDINGS: This regulation was assessed in terms of risk management in relation to smoking only.

There was evidence that residents were smoking in the approved centre, and there was a smell of smoke in the sitting room. The inspection team observed one resident smoking in a communal lounge. There was also evidence of two residents smoking in bedrooms, one of which was a dormitory where three other residents were accommodated. A risk of fire was identified due to residents leaving lit cigarettes on the floor and window ledges. Cigarette butts were also observed in a toilet. The risk register identified passive smoke as a risk. There was an additional risk of physical injury caused by residents smoking indoors.

The approved centre remained non-compliant with the regulation because its risk management policy was not being implemented, 1(a).

During the 2016 Mental Health Commission inspection, the approved centre was found non-compliant with this regulation because of issues with its risk management policy. Since then, the approved centre had provided the inspection with an updated, comprehensive policy.