Mental Health Commission

Focused Inspection Report

(Mental Health Act 2001)

MENTAL HEALTH SERVICE TYPE	Acute Adult Mental Health Care
NAME	Department of Psychiatry, Waterford Regional Hospital
IDENTIFICATION NUMBER	AC0034
REGISTERED PROPRIETOR	Health Service Executive
REGISTERED PROPRIETOR NOMINEE	Mr David Heffernan
MOST RECENT REGISTRATION DATE	1 March 2014
NUMBER OF RESIDENTS REGISTERED FOR	44
INSPECTION DATE	13 and 14 July 2016
PREVIOUS INSPECTION DATE	11, 12 and 13 May 2016
CONDITIONS ATTACHED	None
LEAD INSPECTOR	Orla O'Neill
INSPECTION TEAM	Dr Susan Finnerty MCRN 009711
THE INSPECTOR OF MENTAL HEALTH SERVICES	Dr Susan Finnerty MCRN 009711

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1.0 Mental Health Commission 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.

2.0 Focused Inspection - Scope

2.1 Focus of inspection

This was an unannounced focused inspection of the 10-bed acute unit in the Department of Psychiatry, Waterford Regional Hospital, and took place on site from:

13 July 2016 from 14.00 to 17.00h
14 July 2016 from 09.00 to 12.15h

The following areas were the focus of the inspection:

1. Regulation 9 Recreational Activities
2. Regulation 16 Therapeutic Services and Programmes
3. Regulation 21 Privacy
4. The Rules Governing the Use of Seclusion

2.2 Reason for Focused Inspection

The Department of Psychiatry, Waterford Regional Hospital was inspected on the 11, 12 and 13 May 2016 and was found to be non-compliant with a number of statutory requirements as listed below.

Regulation/Rule/Act/Code	**Risk Rating**
Regulation 7 Clothing	High
Regulation 9 Recreational Activities	Critical
Regulation 11 Visits	High
Regulation 15 Individual Care Plan	Moderate
Regulation 16 Therapeutic Services and Programmes	Critical
Regulation 21 Privacy	Critical
Regulation 22 Premises	High
Regulation 23 Ordering, Prescribing, Storing and Administration of Medicines	Moderate
Regulation 26 Staffing	High
Regulation 27 Maintenance of Records	Moderate
Regulation 28 Register of Residents	High
Regulation 31 Complaints Procedures	Moderate
Regulation 32 Risk Management Procedures	High
Rules Governing the Use of Seclusion	Critical
Consent to treatment, Part 4 MHA 2001	Critical
Code of Practice on the Use of Physical Restraint	Moderate
Code of Practice on the Admission of Children	Moderate
Code of Practice on the Notification of Deaths and Incident Reporting	Moderate

Code of Practice on Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities	High
Code of Practice on Admission, Transfer and Discharge	Low

The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance. In addition, the MHC issued a serious concern immediate action notification to the registered proprietor on the 25 May 2016 in respect of:

1. The Use of Seclusion
2. Recreational Activities and Therapeutic Services and Programmes
3. Sleeping Arrangements and provision of Adequate Privacy

A focused inspection took place on the 13 and 14 July 2016 to verify what action and resolution had taken place with respect to these issues and breach of statutory requirements.

3.0 Focused Inspection - Overview

3.1 Overview of the Approved Centre

The Department of Psychiatry (DOP) was located on the ground floor of Waterford Regional Hospital in Waterford city. It was a 44-bedded unit and comprised two areas - the acute and sub-acute areas. The sub-acute area contained 34 beds and there were ten beds in the acute area. The approved centre was easily accessible from the main hospital and was well sign-posted. The entrance to the sub-acute area was unlocked; the acute area was locked. The acute unit comprised accommodation for 10 residents in a 4-bedded male and a 4-bedded female dormitory and two single rooms. The acute unit had a small outdoor area which functioned essentially as a smoking area and did not provide an attractive environment for residents. The acute unit did not provide any dedicated dining, visiting or communal social facilities for residents.

Eight adult mental health teams, three psychiatry of later life teams and two rehabilitation teams admitted to the DOP. Thus, residents under the care of 13 different multidisciplinary teams (MDTs) were admitted to the approved centre. The general adult and rehabilitation residents from Wexford, whilst in-patient in the DOP, were under the care of three locum consultant psychiatrists and a shared non-consultant hospital doctor who was allocated to the approved centre. The Wexford Psychiatry of Later Life (POLL) residents were looked after by the Wexford POLL team while in-patient in the DOP.

This inspection was focused on the 10-bed acute unit. Twelve residents in total had been accommodated in the acute unit during the course of the inspection, with 10 residents in situ on each day of the inspection. Six of whom were involuntary patients. One resident had been in-patient in the acute unit for almost three years. During the period of the inspection two residents from the acute unit had been transferred for one night each to the sub-acute unit owing to overcapacity in the acute unit. These residents were accommodated in a single room and provided with one to one nursing.

The acute unit was staffed by a Clinical Nurse Manager and three Registered Psychiatric Nurses (RPNs) at the time of inspection. The acute unit would usually have five RPNs during the day but one RPN had been reassigned to the sub-acute unit owing to staff shortages. On the second day of inspection there were three nurses in the sub-acute unit for 32 residents. The staffing level in the sub-acute unit was insufficient to provide appropriate care as required by regulation 26 Staffing 26(2).

3.2 Governance

The Department of Psychiatry was the acute adult mental health approved centre serving a population of 211,000 persons in the Waterford, South Wexford and South Kilkenny area which was a constituent of the HSE Community Healthcare Organisation Area 5.

The Executive Management Team (EMT) was responsible for governance of the approved centre. The EMT comprised senior clinical and administrative staff of the Waterford/Wexford Mental Health Services and included the Executive Clinical Director, Area Director of Nursing, Area Manager for Mental Health Services, the General Manager and Heads of Discipline for

Health and Social Care Professionals. Meetings were held monthly and issues discussed covered all aspects of mental health services in the region, not just the approved centre in the Department of Psychiatry, Waterford Regional Hospital. The minutes of the EMT meetings referenced issues related to the approved centre, including, remedial work to mitigate ligature anchor points, staffing vacancies, and a proposed plan to extend the bed capacity in the acute unit from ten to 14 beds in late 2016.

4.0 Inspection Findings and Required Actions - Regulations

4.9 Regulation 9: Recreational Activities

The registered proprietor shall ensure that an approved centre, insofar as is practicable, provides access for residents to appropriate recreational activities.

Inspection Findings

Since the date of the last inspection, the approved centre had introduced some recreational materials in the acute unit. The provision of recreational activities to the acute unit now consisted of a very limited supply of a couple each of jigsaws, table games, pack of cards, two adult colouring books, a small set of paints and a day old newspaper. There was no dedicated room or space in the acute unit for residents to engage in recreational activity. There was neither adequate provision of materials nor facilities for recreation. Residents' choices were largely confined to spending their day lying on their bed, sitting on a hard chair by their bedside table, walking or standing in the relatively small and cramped main hallway or in the garden which functioned as a smoking area. There was no communal seating area or quiet space for residents to relax. There was no dining room and residents ate all their meals off their bed-side tables. One resident was completing a complex jigsaw puzzle on their bed-table which left them with no table to eat meals. Where a resident wished to pursue an activity, such as reading, listening to music, they were obliged to do so at their bedside.

Residents were risk assessed for participation in recreational activities, such as going for a walk or joining a social activity in the day activities room in the sub-acute unit. Participation in recreational activities such as these depended on nursing staff availability to accompany residents and this was not assured, usually owing to a shortage of staff. An example, cited by staff, was the redeployment of the day activities nurse to ward duties on occasion which led to the closure of the day activities room and programme.

There were no facilities and no staff assigned in the acute unit to support residents to initiate or engage in recreation. The provision of arts and crafts materials or board games alone did not promote recreation. Residents in the acute unit were typically acutely unwell, with variable abilities to initiate, concentrate and engage in solo or group activities. Residents might have benefited from the regular and ongoing presence of staff skilled at working with this resident group and promoting a sense of self-efficacy and optimism and presenting appropriate activities. One resident's ICP record specified psychotherapy whereby the resident was encouraged to use distraction and activity to cope with overwhelming emotions. There was little scope to do so in the acute unit.

There was a television in both the male and female dormitories. There was no television in the two single rooms and those residents had to go into the dormitories and sit adjacent to other residents' beds if they wished to watch television.

At the time of inspection, residents were observed to be predominantly lying in bed or pacing the unit. The environment and staff availability did not provide the opportunity for residents to engage in recreational activity or have the choice of having quiet personal space.

The approved centre was non-compliant with this regulation because it did not ensure, insofar as practicable, access for residents to appropriate recreational activities.

	Compliant	Non-Compliant	
Compliance with Regulation		**X**	
Risk Rating			
Low	Moderate	High	Critical
			X

4.16 Regulation 16: Therapeutic Services and Programmes

(1) The registered proprietor shall ensure that each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan.

(2) The registered proprietor shall ensure that programmes and services provided shall be directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident.

Inspection Findings

There was no evidence of MDT input to the ICP development or review for the Wexford residents in the clinical files inspected. Staff told the inspection team that health and social care professionals did not usually travel from Wexford for the weekly MDT ICP review meetings. The spectrum of care for Wexford residents was thus almost exclusively medical and nursing. Two Wexford residents, despite not having MDT input to their ICPs, were receiving therapeutic input from OT, psychology and social work staff.

It was evident that since the date of the previous inspection, there had been an increased focus on providing therapeutic input to residents in the acute unit. A committee had been set up to develop a therapeutic timetable. Also, the clinical files of Waterford residents showed evidence of therapeutic input from nursing, OT, psychology and social work staff. There was no evidence of MDT input to the ICP development or review for the Wexford residents in the clinical files inspected. Staff told the inspection team that health and social care professionals did not usually travel from Wexford for the weekly MDT ICP review meetings. The spectrum of care for Wexford residents was thus almost exclusively medical and nursing. Two Wexford residents, despite not having MDT input to their ICPs, were receiving therapeutic input from OT, psychology and social work staff.

Residents and staff faced the challenge of a lack of dedicated or appropriate space and accommodation within the acute unit in relation to mounting therapeutic programmes or providing a core therapeutic day. Such a structure to the day might have bolstered and promoted optimal levels of physical and psychosocial functioning of residents. The inspection team spoke with a number of residents and had also observed residents over the two days of inspection. The inspection team asked the staff about what consideration had been given to developing a therapeutic programme and environment within the acute unit. One senior staff member within the acute unit was of the view that the residents would not be capable of therapeutic engagement.

Other staff stated that an MDT group had developed a proposed therapeutic timetable for the acute unit. This was to comprise an: *Art Cart* available each morning from Monday to Thursday; a music session and two creative arts sessions provided by a community arts initiative staff per week; and a “Well-come” group for recently admitted residents. The proposed start date for this programme had been the 5 July 2016 but it had not been implemented. The lack of availability of nursing staff was given as the reason why groups had not gone ahead.

The good faith and intentions of staff in drawing up a therapeutic timetable were clear. The proposed therapeutic timetable struck inspectors as reflecting the availability of sessional staff and resources currently employed within the sub-acute area. There was no evidence that the proposed therapeutic timetable reflected the assessed needs of residents in the acute unit.

The inspection team enquired about the purpose of the *Art Cart* and how it might be used. Staff were unclear as to how the availability of a box of art materials might translate into enhanced engagement and wellbeing in a group of acutely unwell residents with difficulties in motivation, initiation, self-direction and organisation of activities. There was no documented indication of needs assessment and analysis or of a culture of recognition and promotion of optimal functioning. There was also a lack of appreciation of the difference between recreational and therapeutic activities and programmes.

There was evidence that the level of therapeutic input to residents by health and social care professionals had increased for Waterford residents and was in accordance with assessed needs and ICP specification. This was not true for the nine Wexford residents, six of whom were in-patient in excess of seven days yet only one resident had an ICP.

The approved centre was non-compliant with this regulation because:

a) In the absence of ICPs for five Wexford residents, the registered proprietor did not ensure that each resident had access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan 16(1); and
b) It did not provide residents with access to a range of programmes and services directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident 16(2).

	Compliant	Non-Compliant
Compliance with Regulation		**X**

Risk Rating			
Low	Moderate	High	Critical
		X	

4.21 Regulation 21: Privacy

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

Inspection Findings

There was no evidence that any residents had been required to sleep on a bed on a corridor in response to overcapacity in the acute unit since the date of the last inspection. There was a bed list available to the inspection team to confirm this. Staff stated that the protocol now was that the responsible consultant psychiatrists reviewed and risk assessed their residents on a daily basis to identify and prioritise those residents who might safely be transferred to the sub-acute unit in the event of resident numbers exceeding ten. Residents thus transferred to the sub-acute were accommodated in a single-room and had a 1:1 nurse special assigned. During the time of the inspection two residents had been transferred overnight to the sub-acute unit and returned to the acute unit the next day. All beds in the acute unit had surround curtains around their beds, toileting facilities were lockable and resident privacy was respected.

The approved centre was compliant with this regulation.

	Compliant	Non-Compliant
Compliance with Regulation	X	

5.0 Inspection Findings and Required Actions – Rules

5.1 Section 69: The Use of Seclusion

Mental Health Act 2001
Bodily restraint and seclusion
Section 69
(1) "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.
(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.
(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.
(4) In this section "patient" includes –
(a) a child in respect of whom an order under section 25 is in force, and
(b) a voluntary patient".

Inspection Findings

The seclusion room was now operational following replacement of the door between the seclusion room and the en suite lavatory and repairs to the ceiling. There was CCTV signage informing a resident of its operation in the seclusion room. There was a clock visible for any resident being secluded. The room was mostly clean except for dust in the corners, however, the air was stale. There was a fish-eye lens mirror but there was still a blind spot in the room. The walls, bed and floor all comprised a soft surface. There was no evidence that the seclusion room had been used as a bedroom. There was no resident in seclusion at the time of inspection.

Six seclusion registers and the clinical files of four residents (six episodes of seclusion) who had been secluded were inspected and showed that:

- Seclusion had been initiated by either a registered medical practitioner or a registered nurse in all instances;
- Two seclusion orders had not been signed by the responsible consultant psychiatrist or duty consultant psychiatrist within the specified 24-hour timeframe. Seclusion had been used as a last resort, after de-escalation techniques were unsuccessful, to ensure the safety of the resident or others;
- In five instances the resident had been risk assessed prior to the commencement of seclusion. One resident had no recorded risk assessment and was noted to be placed in seclusion for observation. Each of the residents secluded were male and male staff were assigned to provide care in keeping with gender sensitivity;
- In five instances, there was no record of the resident having been informed about the reason, duration and circumstances which would lead to the ending of seclusion;
- Next of kin were informed about the episode of seclusion in two instances, there was no record of this in three instance and one resident refused consent for this;
- In five instances residents were secluded in their own clothes and one resident was dressed in refractory clothing;
- Each of the four residents was observed directly by nursing staff for the first hour of seclusion. Thereafter, each resident was continuously observed by nursing staff and

a record entered in the clinical file every 15 minutes. A two hour nursing review and a four-hour medical examination had been completed as applicable. Each resident had a seclusion care plan;

- One episode of seclusion was extended past 24 hours and the consultant psychiatrist had examined the resident;
- The reason for ending seclusion was noted in four clinical records and no reason was given for two, where the record simply noted that seclusion had ended;
- Two residents were informed that seclusion was ending and there was no record to indicate that the other two residents had been so informed;
- In seven instances the seclusion order form had not been placed in the clinical file as required; and
- There was no record in two instances that the MDT had reviewed the episode of seclusion within two working days.

The approved centre was non-compliant with the following sections of this rule because:

a) There was no record of risk assessment prior to seclusion for one episode 1.6;
b) Two seclusion orders had not been signed by the responsible consultant psychiatrist within the specified 24 hours 3.5;
c) There was no record to indicate that five residents had been informed of the reasons for, duration and circumstances which would lead to the ending of seclusion 3.6;
d) No reason was recorded for not informing next of kin for three episodes of seclusion 3.7(a), 3.7(b);
e) There was no record to indicate that four residents had been informed of the ending of seclusion 7.3;
f) There was no record of the reason why seclusion was ended in two instances 7.4;
g) The seclusion room was not adequately clean owing to dust on the floor in corners 8.2;
h) The seclusion en suite facilities were not adequate owing to a blind spot 8.3;
i) There was no copy of the seclusion order placed in the clinical file in seven instances 9.3; and
j) There was no evidence that the MDT had reviewed the episode of seclusion in two instances 10.3.

	Compliant	Non-Compliant
Compliance with Rule		**X**

Risk Rating			
Low	Moderate	High	Critical
	X		

6.0 Focused Inspection – Findings

6.1 Summary of Findings

Whilst staffing was not the focus of this inspection, the inspection team noted that staffing was an issue at the time of inspection. The acute unit was staffed during the day by a Clinical Nurse Manager and three Registered Psychiatric Nurses (RPNs). The acute unit would usually have five RPNs during the day but one RPN had been reassigned to the sub-acute unit owing to staff shortages. Staff interviewed informed the inspection team that staff shortages over the holiday months had meant that the Day Activities Nurse had been redeployed to ward nursing duties on a number of occasions resulting in the closure of the day activities room and cancellation of therapeutic programmes. On the second day of inspection there were three nurses in the sub-acute unit for 32 residents. The staffing level in the sub-acute unit was insufficient to provide appropriate care as required by regulation 26 Staffing 26(2) and the approved centre was non-compliant.

1. Regulation 9 Recreation

No effective progress had been made in the provision of recreational facilities or opportunities for residents in the acute unit. The schedule of recreational activities submitted by the registered proprietor, with a start date of the 05/07/16 had not proceeded. Residents spent their days lying on their beds, sitting at their bedsides or walking around the small unit. The approved centre continued to be non-compliant with this regulation.

2. Regulation 16 Therapeutic Services and Programmes

There was evidence in the clinical files of some input from health and social care professionals and the provision of individual therapy as specified in a resident's ICP, however, not all residents had an ICP as specified in regulation 15 Individual Care Plan. Seven of the Wexford residents had no ICP and thus no specification of therapeutic needs and interventions as required by this regulation 16 (1).

There was no evidence of therapeutic programme provision based on the assessed needs of an acutely mentally ill cohort of residents and no dedicated therapy facilities within the acute unit. The approved centre was non-compliant with this regulation because it did not provide residents with access to a range of programmes and services directed towards restoring and maintaining optimal levels of physical and psychosocial functioning16 (2).

3. Regulation 21 Privacy

No resident had been required to sleep on a bed located on the corridor since the last inspection. Thus, privacy had been afforded to residents in this regard. The approved centre was compliant with this regulation.

4. Rules Governing the Use of Seclusion

The seclusion room facilities had been repaired and the seclusion room was in commission. There was a blind spot within the seclusion area. The approved centre documentation and

records for seclusion did not meet requirements. The approved centre was non-compliant with this rule.

7.0 Outcome of Inspection

The Inspector of Mental Health Services notified the MHC on the 15 July 2016 of the findings and concerns arising from this inspection. The concerns were the findings of non-compliance listed above. Concerns also included the fact that the approved centre had plans to increase the bed capacity from 10 to 14 beds within the acute unit and this would likely exacerbate the existing problems of no dining, visiting or communal seating areas for residents and no recreational facilities or opportunities within the acute unit.