Inspector of Mental Health Services 2015 Reports

This is the first batch of 2015 inspection reports of the Inspector of Mental Health Services.

This batch of reports contains five other mental health service reports.

Other Mental Health Services Reports 2015

1. Mountain View
2. Brook House
3. Bredagh House
4. Benbulben Lodge
5. Knockroe House

Link below to inspection report documents on the Mental Health Commission website:

http://www.mhcirl.ie/Inspectorate_of_Mental_Health_Services/AC_IRs/

Link below to other mental health service inspection report documents on the Mental Health Commission website:

http://www.mhcirl.ie/Inspectorate_of_Mental_Health_Services/Other_MHS_Inspection_Reports/

Under the Mental Health Act 2001 the Inspectorate is required to inspect annually all Approved Centres for mental health services. In addition, the Inspectorate may inspect any mental health service.

According to the Act, inspections of Approved centres must be with respect to Regulations, Rules and Codes of Practices as well as providing an overall assessment of the quality of care and treatment.

Regulations

Mental Health Act, 2001 (Approved Centres) Regulations 2006 - S.I. No 551 of 2006 cover a wide range of requirements all relating to the overall care and treatment.

Rules

Rules relate to ECT, Seclusion and Mechanical Restraint and are drawn up by the Mental Health Commission. They have the same force as statutory instruments.

Codes of Practice

There are also a number of Codes of Practice in relation to Admission, Transfer and Discharge, Admission of Children, Deaths and Incident Reporting, Working with People with intellectual disabilities, Use of ECT for Voluntary Patients and Use of Physical Restraint. These Codes of Practice are also drawn up by the Mental Health Commission.

Inspection Process

The inspection process involves:

- A visit to the mental health service.
- Informal feedback following the visit to the mental health service.
- Breaches of an urgent nature are communicated immediately to the Commission.
- An initial draft report by members of the Inspectorate team to the mental health service for factual correction.
- Factual correction of the initial draft report by the mental health service.
- Factually corrected draft (version 2) inspection reports are sent by the Inspectorate to the service.
- Factually corrected draft (version 2) inspection reports are sent by the Inspectorate to the Standards and Quality Assurance Division of the Mental Health Commission for appropriate action.
- Before publication, a final screen takes place by the Inspectorate at their Quality, Proof Reading and Editing Committee.

The Inspectorate holds the view that for maximal impact, reports should be published as quickly as possible following an inspection. Reports are now issued on a continuous basis rather than annually as previously.

The main points for this current batch of reports are as follows:

Other Mental Health Services

1. Mountain View

Summary

- Mountain View was a recently constructed, purpose-built residence for 17 residents who required long-term, continuing care.
- All residents had an individual care plan.

Most residents were under the care of the rehabilitation team. This team was insufficiently resourced with medical staff and health and social care professionals. It had 1 x 0.5 Whole Time Equivalent (WTE) social worker and no psychologist

2. Brook House

Summary

- Brook House was a seven-bed residence in the town of Mountbellew. It catered for a mix of long-term residents and also had provision for respite care and assessment.
- Staff were supportive and had a good relationship with residents.
- Residents had access to a range of social and therapeutic interventions.
- While clinical notes were updated regularly by nursing staff there was no evidence of a structured individual care plan (ICP) for residents.
- Residents did not have the means to secure their personal possessions.
- The responsible multi-disciplinary team (MDT) was incomplete as it was currently short an occupational therapist (OT) position. This had a detrimental effect on the assessment of, and care planning for, residents.

3. Bredagh House

Summary

- Bredagh House was an attractive, two-storey house, situated on a busy residential road in the east of Galway city, directly across the road from the Galway campus of the Galway Mayo Institute of Technology (GMIT).
- All residents were actively engaged in therapeutic programmes, outside of the house.
- The same weekly Health Service Executive (HSE) charge was applied to all residents, without apparent individual assessment.
- All residents were on a self-medicating programme, which was operating very successfully.
- There was a strong ethos of recovery and encouraging residents to be as independent and autonomous as possible.

4. Benbulben Lodge

Summary

- The assistant inspector had difficulty gaining access to the community residence because the residence was gated by a barred metal electronic gate which was shut. The assistant inspector could find no other means of access to the residence. No doorbell could be located by the assistant inspector around the area of this gate, in particular, around the area where the coded keypad to the gate was located.

- Twin bedrooms were small and afforded no privacy and dignity to the residents using them.
- There was no complaints procedure displayed in the residence.
- The prescription sheets used by the service for both prescribing and administrating medicines were outdated in that they did not meet current practice standards and needed to be reviewed.
- Although staff handled residents' monies, a financial policy in relation to this could not be produced by staff of the residence upon request by the inspector.
- The individual care plans (ICPs) were multidisciplinary in content.
- There was a good choice of main meal each day.

5. Knockroe House

<u>Summary</u>

- An inspection of Knockroe House, a 14-bed community residence in Castlerea, Co. Roscommon, was initiated on foot of anonymous information received by the Mental Health Commission (MHC). The information received was of such concern that the Chief Executive (CE) of the MHC requested the Acting Inspector of Mental Health Services to conduct an unannounced inspection. This inspection took place on 16 and 17 April 2015. Two further anonymous complaints were also received by the MHC relating to Knockroe House since the initial complaint. A follow-up inspection took place on 8 June 2015 to ascertain what steps the service had undertaken following the inspection of 16 and 17 April 2015