INSPECTORATE OF MENTAL HEALTH SERVICES

National Overview Meeting

Directors of Nursing

10 December 2013

Background

In 2012 the Inspectorate reported on the views of the disciplines of occupational therapy, clinical psychology and social work. In 2013 the Inspectorate met with the Executive Clinical Directors (ECDs) and the Directors of Nursing (DONs), including Area Directors of Nursing. The Inspectorate's initial intention was to invite Area Directors of Nursing only. However, since not all Area Directors of Nursing had been appointed, the forum was expanded to include Directors of Nursing.

Their views were sought in relation to their experiences as DONs and on how mental health service delivery might be improved. The Directors of Nursing were asked to complete an online survey and were invited to participate in an open-forum discussion chaired by the Inspector of Mental Health Services.

METHOD

All 36 DONs, including Area Directors of Nursing, were notified of the survey and the national overview meeting via email. A total of 22 survey responses were received giving a response rate of 61%. Thirty DONs attended the national overview meeting on the 10 December 2013.

The online survey asked the following questions:

1. Which mental health service area do you work in?
2. How many nursing vacancies are there in your area?
3. How many nursing posts in total are there in your area?
4. How many 24 hour nurse-staffed community residences are in your area?
5. What opportunities are available for non-mandatory training for nurses in your area?
6. To what extent are service users involved in governance in your area?
7. How embedded is the concept of Recovery in your area?
8. To what extent are services in your area community based?
9. What clinical outcome measures are used in your area?
10. In your opinion, what are the three most important aspects of a quality mental health service?
11. In your view, how well does the clinical governance structure work in your area?

RESULTS OF ONLINE SURVEY

Twenty-two DONs responded to the survey. All respondents answered all questions.

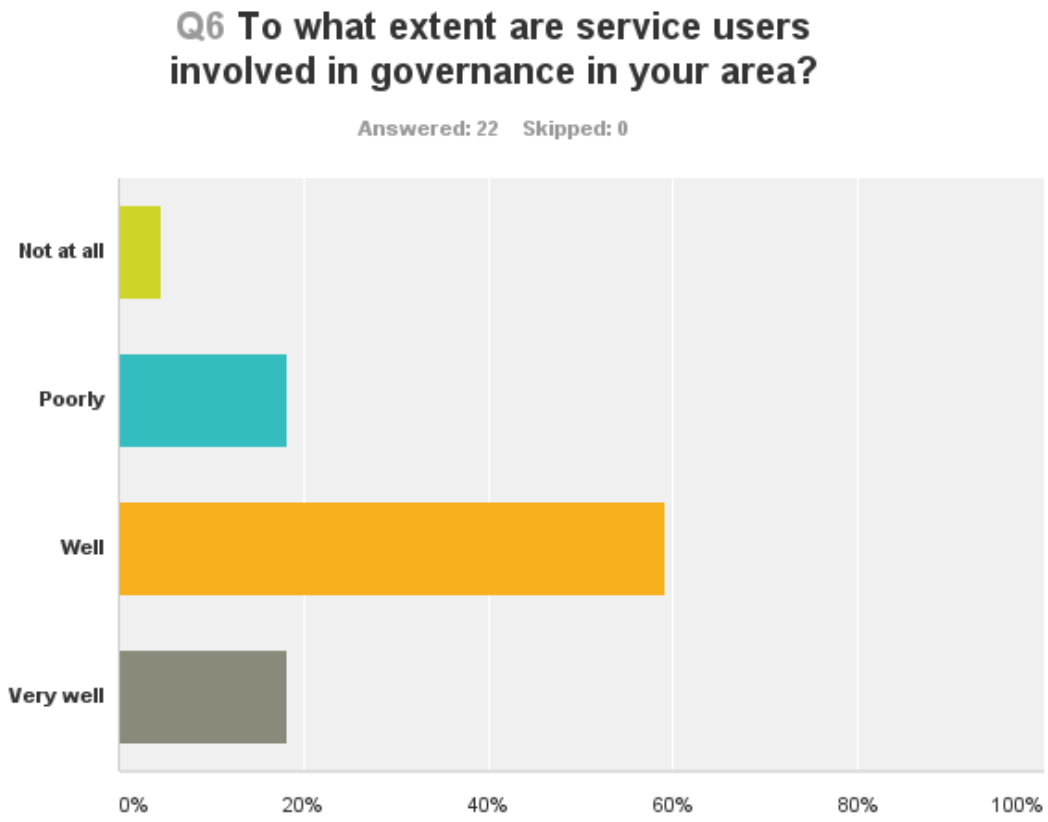
Q. 1, 2 and 3: Number of Nursing Vacancies and Posts in your area

There was a cross section of areas represented in the responses of the DONs. A number of Area Directors of Nursing and DONs answered these questions so in some cases there was a crossover of figures, for example, the Area Director of Nursing for a particular area supplied figures for the table below but those figures were the sum total of partial figures supplied by a number of Directors on Nursing working within the same area.

Area	Number of Nursing Vacancies	Total Nursing Posts in Area
North Dublin	14	196
HSE West	25	160
HSE South	15.3	150
HSE South	nil	112
Independent	12	"N/A"
HSE DNE	9	183.02
HSE West	"unknown"	160
HSE DNE	12	126
HSE DML	5	66
Independent	4	52
HSE West Independent HSE DNE Independent HSE DNE Independent HSE DML Independent HSE South CAMHS HSE DML HSE South HSE DNE	6 None 21 None 24 None 37 None 10 "don't know" 10 7	170 38 134 6 288 250 250 50 40 150 358 135

Q.5 What opportunities are available for non-mandatory training for nurses in your area?

- Some 2
- Available 12
- Good 6
- None 1
- Response lacked clarity 2



Four respondents replied "poorly" and one responded "not at all". One respondent indicated that service users were involved in the recruitment of staff. Service user representatives were on the ECD Management Team in two instances and also on the local management team. In another area a service user representative was being actively sought to participate on the Area Management Team. Another area had a service user representative on the Service Management Committee. Two areas had both a service user and a carer involved on Clinical Governance Committees. In

another area, the service user representative attended the Senior Management Team meeting and was a member of the policy and procedure forum. In one area, the service user representative was a member of the Senior Management Team but did not like to attend these meetings and received the minutes of these meetings. In another area, the service user was represented at all levels.

Q7: How embedded is the concept of Recovery in your area?

Not well embedded	1
In progress	1
Reasonably	1
Good	4
Well	6
Very well	9
Response lacked clarity	1

In the majority of cases respondents indicated that the concept of Recovery was embedded “well” or “very well”.

Q8: To what extent are services in your area community based

Little	3
Good	3
Well	9
Extensively/100%	7
Response lacked clarity	1

In the majority of cases respondents indicated that the extent that services in their areas were community based were “well” or “extensive”. The respondent from one Health Service Executive (HSE) area indicated that community teams were under resourced and that there was a great need for the development of day services. A respondent from a second HSE area indicated that there was poor resource provision for day hospitals and also geographical challenges made such provision difficult because of the distances involved across the catchment area.

Q9: What Clinical Outcome Measures Are Used In Your Area?

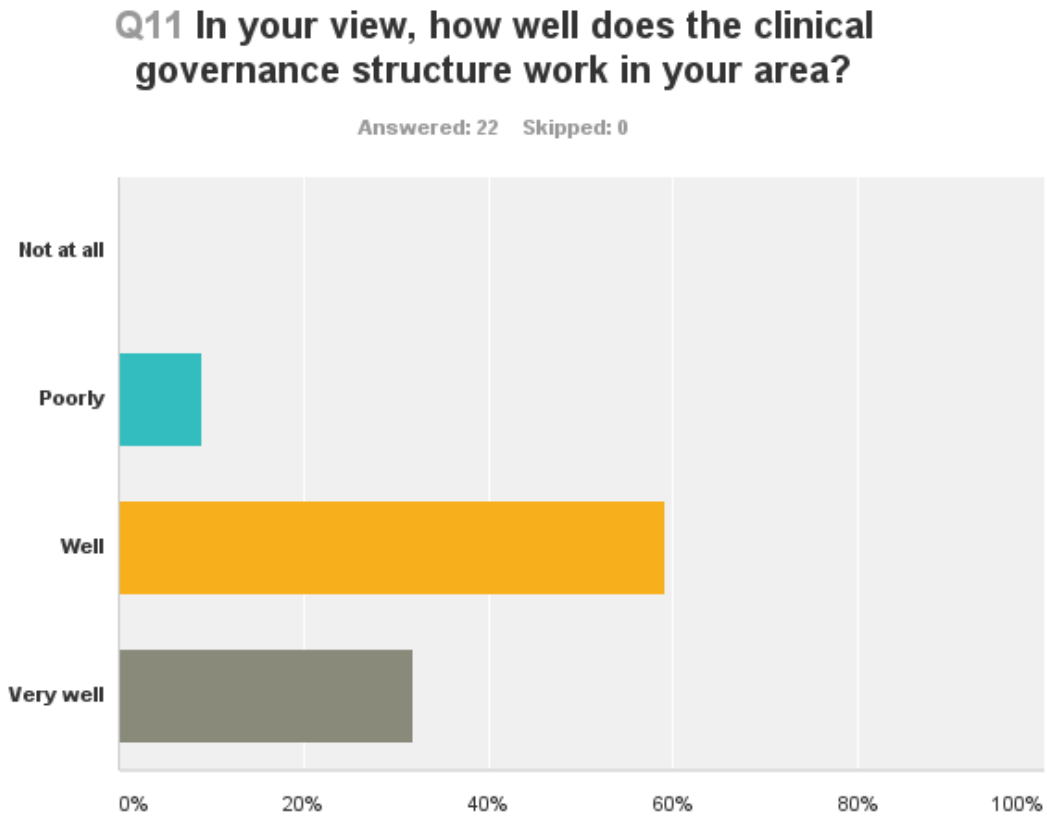
- None 2
- Not known 1
- Under development 1
- KPIs 8
- HRB stats 1
- Patient satisfaction 6
- Other 4

Two responses indicated that clinical outcome measures were not used or were poorly developed. One respondent did not know and another indicated that they were under development.

Q10: In your opinion, what are the three most important aspects of a quality mental health service?

1. Ease of Access 11
2. Recovery focused 8
3. Service User Involvement 9
4. Choice / Individual needs / person-centred / Good MDT working / Well-educated, high functioning staff / seamless service

Accessibility and responsiveness to the service user were the most frequently cited important aspects of a quality mental health service. Being recovery focused and involving service users were also deemed important by respondents.



Most respondents indicated that the clinical governance structure worked “well” or “very well” in their areas. Difficulties identified were that the executive posts and functions needed to have a more hands-on approach to operational and service user issues and less of a strategic role. Another indicated that the Catchment Management Team was somewhat ineffective and was by-passed by reporting relationships and consultant independence in their clinical practice.

NATIONAL OVERVIEW MEETING WITH DIRECTORS OF NURSING

Directors of Nursing were invited to meet and discuss issues arising from the survey, their perspective on current mental health services and any improvements that they felt could be made in the mental health services. Thirty Directors of Nursing attended the National Overview Meeting. Their views are summarised as follows.

Nursing Vacancies

“The question of how many nursing vacancies existed in the mental health service is an impossible question to answer accurately. The Department of Health used to have an approved number. However, within the HSE, if someone retires, the post no longer exists. It is removed from the system. So the actual vacancy no longer exists as it is cancelled out by the retirement of the post holder. What is a “vacancy” needs

to be defined. Nursing vacancies are out of the control of the Nursing profession. The better question to ask would be “what is the floor of staff required in order to practice safely and efficiently”? Trying to get clarity as to what is the “floor” of staffing is also difficult. Without an established baseline figure it is difficult to quantify.”

“Unions and management may differ on what staffing ought to be. Also, there is conflict between National Policy and Mental Health Policy *A Vision for Change* (AVFC), in respect of cutting posts (National Policy) and reconfiguring posts (AVFC policy).”

“A lot of personnel were not interested in working in the Dublin area. There is a shortage of psychiatric nurses in the Dublin area and there are no panels. A meeting was held between the DONs and the new National Director on this issue. The HSE, in the meantime, has taken on some graduate students. A “Dublin Weighting” allowance should be introduced in order to attract nurses to Dublin.”

“In respect of the graduate programme in nursing, some newly qualified staff have gone to England, Australia or are working in private hospitals, or are taking on six-monthly contracts which are more appealing. Therefore, the pool of nurses available for work is quite shallow at present. There is no consistency of staffing and an overuse of agency nurses and no timely recruitment – it takes so long to get a person in place and can take up to a year.”

“There is a continuous struggle introducing healthcare assistants in respect of the time spent in relation to industrial relation (IR) issues when trying to introduce this change. Trying to introduce change and to do things in a different way is difficult.”

“One hospital went through the Labour Relations Commission (LRC) in relation to healthcare assistants. One DON had overseen the training-up of multi-task attendants (MTAs) who then became healthcare assistants and then ended up with no one to prepare food or clean because they could not recruit MTAs. There is a need to set baseline of absolute minimum amount of staff on a floor.”

“Front line clinical services should be maintained and other areas of staffing such as porters.”

“Community staffing suffers as there is a need to ensure that the in-patient units are covered. Nursing has been active in developing new services in tough times and good times. Now nursing is looking at pulling back nurses from the community in order to safely and adequately staff the in-patient facilities.”

“In two HSE areas, staff are being pulled from community care areas in order to staff the acute care facilities, so crisis intervention teams were being depleted of staff.”

Feedback from Service Users

The DONs were then asked regarding feedback from service users and their families on what they felt about this situation. One DON had met recently with service users

and their families and told them that they were actively looking at developing new community services. But ironically this was against the backdrop of having to pull back resources from community services into residential ones. He reported that service users wanted services that were more accessible and local to them with the focus more on outpatient care with more input from occupational therapists and social workers.

Outcome Measures

The DONs were then asked about the issue of measurement in general and whether some managers have a system of measurement.

Representatives from one area answered by saying that they monitor the length of time service users are attending outpatient clinics and also the case load of nurses. Research had been carried out on the issue of work force planning by a particular HSE hospital.

“Low staff morale leading to absenteeism, leading to sick leave, leading to long term sick leave, leading to leaving the service. Absenteeism is the biggest indicator of poor staff morale.”

Measurement of patient satisfaction

There are no robust systems in place in respects of this.

How could nursing staff be involved in generating this information?

“Nursing staff can provide information, for example, on the number of patients that can be catered for in a particular service.”

“Waiting times for outpatient clinics were being monitored and nursing caseloads were being monitored.

One HSE hospital had undertaken some research on the area of manpower planning. The research comprised attention to skill mix, absenteeism and why absenteeism is happening and how this affects the level of service provision and service users themselves. Lack of money, poor innovation, and poor job satisfaction resulted in increased absenteeism.

Community Services

“Community services nursing staff numbers are dwindling. Services are slowly closing in Dublin North area. Service users and family representatives would be

happy with service provision in the community rather than in a hospital setting, preferring to be nursed in the community."

"Crisis intervention teams are not fully staffed."

"There should be a 24-hour presence in community centres and they should not be operating on a nine to five, Monday to Friday basis as they are presently."

One DON said that an audit of in-patients, whose length of stay was less than five days, found that 80% of these presented for admission after 6pm.

The consensus of the group was that there should be more community based assessment. Need to describe exactly how this would work.

"It is only nurses and medical staff who will support a seven-day service in the community. It was the view of the group that no occupational therapist, social worker or psychologist will work over the weekend. A concerted effort needs to be made by all of the multidisciplinary team (MDT) to support seven-day community services."

"The issue of medical staffing out of hours is a critical issue. NCHD crisis is causing a problem."

"Basic grade social and health care professionals are coming off national panels not able to do core assessments due to lack of experience. No on-call system for social and health care professionals after 5pm."

"Key working should not be focussed solely on nursing staff. This needs to change nationally."

MDT Record Keeping

Individual Care Plans (ICPs) –What is the reason for having 60% full compliance with ICPs (2013)?

It was the view of the DONs that nurses are the only personnel contributing to care planning.

"It is the clinical director who is the clinical leader. It needs to be driven from the clinical director down. This issue comes up frequently at management meetings. There are inconsistencies in different areas."

"If the multidisciplinary team take ownership of ICPs then they will work."

"Nursing staff sometimes feel blamed for services not being compliant with the Regulations in respect of individual care planning. Nursing staff put a lot of work into it. Some consultant psychiatrists have not bought into care plans."

“Multidisciplinary team (MDT) record keeping is another big issue. Mental health care is still dominated by medical model. In a number of cases there are sets of clinical files in different offices, not one composite set of notes.”

“Number of beds in approved centres is dropping massively, in a number of years, service users will not be in approved centre until very unwell.”

“Social workers should engage earlier with service users. Focus needs to be in the community and get the engagement in community services more rapidly.”

“The Inspectorate should also focus on what is maintained in the clinical files and what is not.” The issue of health and social care professionals maintaining separate clinical notes from those available in a service user’s clinical file was discussed. In one centre, other disciplines did not have separate notes. A lot of work had been done in this area to maintain a composite clinical file. “Individual professionals need to take responsibility and they should be held to account.”

“There should be more MDT personnel from the service present on the day of inspection of the approved centre. The Inspectorate needs to be more assertive when asking for a presence of personnel and files.”

“Unannounced visits are not a problem per se. Approved centres need to have an MDT present when an inspection team visits a service. Notice to ensure that all professionals are there on the day of inspection. The Inspectorate should be more assertive in demanding other professionals be present when inspection takes place.”

“Every service is different. Some services are spread across large areas.”

It was agreed that the Mental Health Commission was an agent for change.

“During inspections of approved centres, the Inspectorate meets with nurse representatives. Other health professionals are then called to the feedback meetings. They should be present when questions are being asked on clinical files, as it is not for nursing staff to answer for the work of other disciplines.”

“Consultant psychiatrists are leaders and they need to lead.”

The application of a condition on one approved centre was acknowledged by the DON of that centre to have been helpful to drive change.

Individual Care Planning

One DON said that all DONs need to be more assertive regarding MDT notes being present in all residents’ clinical files and about representatives of the MDT being present on inspection.

“If a nurse is not driving ICPs then there are no ICPs.”

“Reporting structures may vary in services. Governance is different in each service.”

“A sticker co-ordinator should be used in the composite set of notes that make up the resident’s clinical file so that different colour stickers to identify the individual clinical entries of each discipline would be evident in the service user’s individual clinical file.”

Principal issues

The Directors of Nursing were asked about what they perceived their individual biggest difficulties were within the mental health service:

Assistant DON, in one approved centre said that the biggest job is to get ready for inspection. His role incorporated a compliance officer role. If conditions were attached then this really made things happen in respect of achieving compliance. Training was very useful to attain compliance. This service now uses an audit tool in preparation for inspection going through Articles, Rules and Codes of Practice one by one.

“Consultant psychiatrists are the drivers and it won’t work unless they lead.”

“Nursing staff sometimes feel that nurses are being inspected and not the service. Other health professionals need to be present during inspections.”

“Staffing levels – cannot retain new graduates. How much emigration is affecting nursing is a national problem.”

“Nurses have led change and have been part of change and will be involved in change in the future.”

“When experienced community nurses are taken out of the service, it leaves a gap in the service.”

“Discontinuation of the community allowance has made it difficult to get staff to work in community situations. Therefore the service gets recent graduates who are not as experienced to do the work.”

“Fully trained operational MDT teams and better interaction between MDT teams and GPs are necessary. Emergency Departments require a mental health practitioner presence.”

“Nine to five, Monday to Friday hours do not suit people with crisis.”

“Trying to introduce skill mix and develop community mental health teams.”

“Is there a role for MHC/HSE to design a care plan template?”

“Admission of children and parental consent in respect of 16-17 year olds.”

“Admission of children into adult units, length of stay of children in adult units. CAMHS units are only setup for planned admissions.”

“Huge problem in nursing manpower for future if not addressed now. The Mental Health Commission and National Director Mental Health need to address this.”

“Loss of senior staff in one area has put pressure on staff left in the service to keep same level of staff in place. Difficulty in releasing staff from in-patient units for training”“

“There is a lack of clerical administration in community mental health teams.”

“Not having enough psychiatric nurses as they are not available for recruitment. It will be nurses that will lead care pathways.”

Conclusion

There were thirty-six Directors of Nursing, including Area Directors of Nursing, in Ireland in 2013. Thirty attended the national overview meeting on the 10 December 2013. A total of 22 survey responses were received giving a response rate of 61%.

The main issues discussed were nursing vacancies, community services, the process of inspection of approved centres. MDT working and care planning. The issue of vacancies pertained mostly to HSE areas as all private mental health areas reported that staffing was not an issue. It was difficult to quantify the number of vacancies that existed as posts ceased to exist upon the retirement of the post holder. It was reported that it was only nursing staff who were available to work unsocial hours and at weekends so it was difficult to envision the possibility of a fully-staffed MDT community service outside Monday to Friday 0900h-1700h.

In respect of care planning, it was agreed that nursing staff were the main drivers of Individual Care Planning and that all members of the MDT need to take professional ownership of the process as was their legal duty. Nursing staff were to the forefront of the inspection process in regard to the annual inspections of approved centres and again it was agreed that fair representation from the MDTs should be present during all inspections. It was reported that not all disciplines made entries into each resident’s clinical file and that separate notes were maintained, particularly by social work and psychology staff and it was difficult for members of the MDT such as nursing and medical disciplines to view these notes in order to gain an overall picture of the resident’s journey through the pathway of care and treatment.