



Report of the Inspector of Mental Hospitals

for the year ending
31st December, 2003

BAILE ÁTHA CLIATH
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51 FAICHE STIABHNA, BAILE ÁTHA CLIATH 2,
(Teil: 01 - 6476834/35/36/37; Fax: 01 - 6476843)
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DUBLIN
PUBLISHED BY THE STATIONERY OFFICE
To be purchased directly from the
GOVERNMENT PUBLICATIONS SALE OFFICE,
SUN ALLIANCE HOUSE, MOLESWORTH STREET, DUBLIN 2,
or by mail order from
GOVERNMENT PUBLICATIONS, POSTAL TRADE SECTION,
51 ST. STEPHEN'S GREEN, DUBLIN 2,
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or through any bookseller.

€10.16

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Introduction

To the Minister for Health and Children

In pursuance of the provisions of Section 247 and 248 of the Mental Treatment Act, 1945, I am submitting to you my report for the year 2003 on psychiatric hospitals and services and the care of patients therein. This is my sixteenth and final report since my appointment in November, 1987.

In Chapter 1, the report details some general matters affecting the psychiatric services at the time of inspection and highlights the main developments envisaged in the psychiatric services in each health board. The report then proceeds to deal with each individual service. Each health board is allocated a separate chapter, with a chapter also being devoted to registered psychiatric hospitals. Finally, there is a presentation of the latest statistical information on the psychiatric services.

I carried out the inspections in all hospitals and services with the assistance of Doctor Liam Hanniffy, Assistant Inspector of Mental Hospitals. The inspections were enhanced by the professional advice and guidance of Mr. Michael Hughes, Assistant to the Inspector of Mental Hospitals. Ms. Marie Cuddy and Ms. Ailish Corr of the Department of Health and Children assisted with the compilation of this report.

As in previous years, we followed the protocol of first presenting a draft report to the Chief Executive Officers of each of the health boards and the Medical and Administrative Directors of private and voluntary hospitals for their observations. In matters relating to factual errors as pointed out by them, our reports were amended and finally prepared for presentation to the Minister for Health and Children. The reports presented here are summaries of the final reports. More detailed accounts of our inspections were presented to the Chief Executive Officers of each health board and to voluntary and private hospitals.

On behalf of the Inspectorate, I would like to thank the many individuals in the psychiatric services throughout the country who co-operated fully with us in providing all necessary information relating to their services and for affording us access to information requested.

Those who wish to obtain more statistical information about the activities of Irish psychiatric services and quantitative data concerning the facilities they provide, should consult the “Activities of Irish Psychiatric Services” published by the Health Research Board in association with the Department of Health and Children on an annual basis.

Dermot Walsh
Inspector of Mental Hospitals

THE INSPECTORATE OF MENTAL HOSPITALS —2004



left to right - Dr. Liam Hanniffy, Assistant Inspector of Mental Hospitals, Dr. Dermot Walsh, Inspector of Mental Hospitals, Mr. Michael Hughes, Assistant to the Inspector of Mental Hospitals

Glossary

A & E	Accident and Emergency.
Accident	An unplanned event which causes injury to persons, damage to property, or a combination of both.
ADON	Assistant Director of Nursing.
Assertive Outreach Team	A multi-disciplinary team, under the direction of a consultant psychiatrist, that engages high-risk mentally ill patients with complex needs and assesses needs comprehensively in order to develop individual tailored care packages in community settings to meet those needs (patients have a diagnosis of severe mental illness, risk of self harm or neglect, unstable accommodation and a history of failure to engage with normal treatment and support services).
Catchment Area	Refers to the area traditionally served by a district mental hospital. In many cases, catchment areas correspond with county boundaries. In Dublin and Cork, the catchment boundaries correspond in most cases with those of the community care areas of the health boards.
Clinical Director	The clinical director is the consultant psychiatrist responsible for a psychiatric hospital and services in the catchment area served by the hospital. Clinical directors may also be known as Chief Psychiatrists/Resident Medical Superintendents, (see RMS below).
Clinical Guidelines	Systematically developed statements that guide action to assist practitioners' and patients' decisions about appropriate health care for specific clinical circumstances.
CMHN	Community Mental Health Nurse.
CNM	Clinical Nurse Manager (Grade of Nurse Manager).
Community Residences	
Definition	<p>L = Low-Support: Community residences for patients who require some degree of shelter and support, whose social functioning is good enough to ensure that their basic needs can be met in an autonomous way. Staff support is minimal and unobtrusive.</p> <p>M = Medium-Support: Community residences promoting the concept of community integration and independence for patients with some difficulty in carrying out the basic tasks of daily living and requiring varying levels of staff support relating to individual need.</p>

H = High-Support: A community residence providing 24- hour in situ supervised care for patients with special needs, with the aim of ensuring optimum residential support in order to maximise independence and to ensure living in the community is viable and satisfactory.

CPR	Cardio Pulmonary Resuscitation.
Day Centre	A day centre provides social care for patients and it may also offer treatment. Rehabilitation and activation services may be provided and may include occupational therapy, social skills training and light industrial therapy.
Day Hospital	A day hospital provides comprehensive treatment equivalent to that available in a hospital in-patient setting for acutely ill patients. A range of assessment and investigative procedures and treatments is carried out. The day hospital acts as the focus of psychiatric care in an area and is primarily for active treatment of patients with psychiatric disorders.
De-designation	The term used to indicate that a part of a psychiatric hospital has been formally separated from the main hospital and whose patients are no longer considered to be psychiatric patients. Accommodation for older people and patients with intellectual disabilities in a number of hospitals has been de-designated.
DON	Director of Nursing.
ECT	Electro-convulsive therapy.
ESF	European Social Fund.
FBAO	Foreign body in airway obstruction.
GP	General Practitioner.
Home Care Team	A multi-disciplinary team, under the direction of a consultant psychiatrist, that provides assessment and intensive treatment, frequently on a domiciliary basis, for those with severe mental illness on a reasonably continuous basis as an alternative to hospitalisation, or to facilitate early discharge from hospital, where hospital admission has been necessary.
Hospitalised patient (in-patients)	Patients receiving care and treatment in a registered hospital or unit under the Mental Treatment Act, 1945 and amending legislation, including patients on leave and patients absent without leave.
ICD	International Classification of Diseases.
Integration	May refer to the integration of male and female patients in the same ward or the integration of male and female nursing staff or both.
Intensive Care Unit	A specialised unit within the mental health service providing assessment and treatment for patients for whom management on an acute ward is not possible.

Long-stay	A patient who has been continuously hospitalised for over one year.
Mental Health Centre	The mental health centre acts as the centre of the psychiatric service in a sector and the sector team has its headquarters there. It may provide a number of twenty-four hour care beds for assessment and crisis prevention purposes and incorporate an acute day hospital, an essential component to a community-oriented psychiatric service.
New long-stay	A patient who has become continuously hospitalised for over one year in the past year.
NCHD	Non-Consultant Hospital Doctor. A doctor in one of these posts is usually in training for a consultant post in psychiatry or as a general practitioner.
Non-Hospitalised patients (out-patients)	Persons receiving advice, treatment and after care at a consulting room, clinic, day hospital, day centre, in pursuant of the Mental Treatment Act, 1945 and amending Legislation.
Peg Feeding	Percutaneous endoscopic gastrostomy — a surgical opening (stoma), through the skin into the stomach.
Policy	A plan of action that governs mental health service activity and which employees are expected to follow.
Protocol	A written plan specifying the procedures to be followed in providing care in defined situations (Protocols specify who does what, when and how).
PRN Prescription	Pro re nata prescriptions. Prescriptions given, as necessary.
Planning for the Future	Title of the Report of a Study Group on the Planning of the Psychiatric Services. December 1984 (PL 3001).
PUM	Acronym for person of unsound mind. Such persons are a category of patient who may be admitted to and detained in a district mental hospital under section 162 of the Mental Treatment Act, 1945.
Restraint	Restraint of a patient is the application of clothing or other material whereby the movements of the body or any part of the limbs of a patient are restrained or impeded (S.I no. 261 of 1961).
Risk Assessment	The gathering of information of the causes of harm and of identifying specific risk factors of relevance to an individual in the context in which they may occur, in order to consider appropriate measures to remove or reduce risk.
Risk Management	A statement of plans and an allocation of individual responsibility for translating collective decisions into action. Risk management involves having processes in place to monitor risks: access to reliable and up-to-date information about risks, the right balance of control in place to ensure cost effective use of risk process and a series of well defined steps to support better decision making through good understanding of risks and their likely impact.

RMHN	Registered Mental Handicap Nurse.
RMS	Resident Medical Superintendent. The RMS is the consultant psychiatrist responsible for a district mental hospital with defined functions under the Mental Treatment Act, 1945.
Seclusion	Seclusion of a patient means the placing of a patient (except during the hours fixed generally for patients to retire for sleep) in any room alone and with the door of exit locked or fastened or held in such a way as to prevent egress of the patient (S.I. No 261 of 1961).
Sector/ Sectorisation	Planning for the Future (see above) described sectorisation as the process of providing a comprehensive service for a population of known size normally resident within a clearly defined district. The recommended population for a sector is 25,000-30,000. In many parts of the country, psychiatric services are organised in sectors on the model recommended in the Report.
Secure Unit (Central Mental Hospital)	Units providing care and treatment under conditions of greater security than those ordinarily provided by the mental health service. Patients require special treatment and care because of dangerous or criminal propensities and the likelihood of seriously endangering self or others. These units must then subscribe to the management ethos and practice of the developing forensic psychiatric service, such as the Central Mental Hospital (CMH).
Skill Mix	The blend of skills needed amongst a team of staff to ensure effective health care delivery.
Temporary Patient	A patient who is suffering from mental illness believed to require for his/her recovery not more than six months suitable treatment and is unfit on account of his/her mental state for treatment as a voluntary patient or who is an addict and is believed to require, for his/her recovery, at least six months preventive and curative treatment and who is detained on the legal authority of a Temporary Patient Reception Order.
Tracking and Trending	Tracking — recording of data and assimilated information. Trending — comparison of information produced in tracking reports over a period of time.
Violence and Aggression	Any incident in which a patient, staff member or visitor is abused, threatened or assaulted in circumstances related to <ul style="list-style-type: none"> (a) Patient — care in hospital or community; (b) Staff — to their work; (c) Visitor — whilst visiting a hospital or out-patient facility.
WTE	Whole-time equivalent.

CHAPTER ONE

THE PSYCHIATRIC SERVICES IN 2003 — An Overview

THE REPORT

This is the final report of the Inspector of Mental Hospitals as provided for by the Mental Treatment Act, 1945. The process of inspection and reporting will be taken over in 2004 by the Inspectorate of Mental Health Services as established by the Mental Health Act, 2001. This present report consists of two main sections. The first presents material on general issues, the second, a resumé of matters in each health board and service. The complete reports on each service, unit-by-unit, ward-by-ward, and community facility by community facility, are too lengthy to include in this publication but are available on request.

GENERAL STATE OF MENTAL HEALTH SERVICES IN 2003

According to the figures supplied to the Department of Health and Children by service providers, there were 3,701 patients resident (including those on parole) in psychiatric hospitals (public and private) and acute psychiatric units on 31 December 2003. Of these 3,266 were in health board hospitals and the remainder in private hospitals. During that year there had been 23,234 admissions to these in-patient facilities, of which 2,349 were non-voluntary. Details of the socio-demographic and medical characteristics of resident and admitted patients in each individual service can be found in the body of this report, and in more detail in *Activities of Irish Psychiatric Services 2003*, to be published by the Health Research Board later this year.

The majority — almost 55 per cent — of patients in hospital at the end of 2003 were long-stay, being continuously hospitalised for over one year, with over one third of them continuously hospitalised for over five years and the majority of the long-stay were aged over sixty-five years.

CHANGES AND PROGRESS 1987 — 2003

As this Inspectorate concludes the work it began in 1987, it is worth looking back at the progress that has been made in this time and also at what remains to be done.

In 1987 there were 11,114 patients in psychiatric inpatient care: by 2003 this number had fallen to 3,701. In 1987 there were 11 mental hospitals with upwards of 400 patients or more, St. Brendan's and St. Ita's in Dublin, St. Joseph's, Limerick, Our Lady's, Ennis, St. Loman's, Mullingar, St. Luke's, Clonmel, Our Lady's, Cork, St. Finan's, Killarney, St. Mary's, Castlebar and St. Brigid's, Ballinasloe. Four of these hospitals, St. Brendan's, St.

Ita's, St. Brigid's, Ballinasloe and Our Lady's Cork had over 800 patients. In Our Lady's, Cork there were over 900 patients distributed in 46 wards. By 2003, Our Lady's Hospital, Cork and Our Lady's Hospital, Ennis, had closed and plans for the closure of St. Brendan's Hospital, St. Joseph's Hospital, St. Finan's Hospital and St. Mary's Hospital were at an advanced stage: all had fewer than 150 patients (St. Brendan's -133, St. Joseph's -117, St. Finan's -110 and St. Mary's — 90). By the end of 2003, the majority of admissions were to general hospital units rather than to the old psychiatric hospitals.

In 1987 there were 27,856 admissions to all hospitals and units of which 7,934 (29%) were first admissions and 11% of all admissions were involuntary. In 2003, there were 23,234 admissions of which 5,591 (24%) were first admissions and 10% of all admissions were involuntary.

At the end of 1987, there were 233 community residences providing 1,625 places; by 2003 these figures had risen to 418 residences and 3,210 places.

In 1987, there were 186 consultant psychiatrists; by 2003 this number had become 281. At the end of 1987, specialised services in psychiatry were limited to 18 consultants in child and adolescent psychiatry, no consultants in later life psychiatry and three in forensic psychiatry. In addition, there were 21 consultants working in institutional-based services for the intellectually disabled. By the end of 2003, there were 52 consultants in child and adolescent psychiatry, 21 in later life psychiatry, five in forensic psychiatry in addition to two posts for the psychiatry of the homeless, six consultants in the psychiatry of substance abuse, seven in liaison and consultation psychiatry in general hospitals and five in rehabilitation.

In 1987, there were numerous vacancies for social workers, psychologists and occupational therapists such that multi-disciplinary team working was often not possible; in 2003, although the matter had improved somewhat, there were still considerable gaps in the filling of these posts.

In 1987, only five services; South Lee, Waterford, St. James's, Dublin, Limerick and West Galway provided acute admission units in general hospitals for their catchments. In addition, there was a limited facility in St. Vincent's Hospital, Elm Park, not serving a catchment area, a unit beside a district hospital in Skibbereen for the West Cork service and a unit beside a general hospital in the Tipperary service. The Donegal service had been operating a unit at the Letterkenny General Hospital but this had temporarily closed. At the end of 2003 there were 21 such units with a further three ready for occupation and operation early in 2004, at Portlaoise for the Laois/Offaly service and new replacement units at St. Vincent's Hospital, Elm Park, and James Connolly Memorial Hospital, Blanchardstown.

CHANGING MODELS OF SERVICE DELIVERY

At the end of 2003, while a small number of services such as Cavan/Monaghan and parts of the Area 4/5 service in Dublin had evolved towards an up-to-date model of out-reach and home-based care provision, the majority were still operating partially developed conservative community models. In general, service providers seemed unsure and insecure in

their comprehension of the theory and practice of out-reach, home-based, crisis resolution and early intervention initiatives.

On the organisational level, health boards had not, it appeared to the Inspectorate, reconsidered the utility of their current catchments in the light of newer models of care delivery being adopted elsewhere. It was rather the case that current geographic delineations were being maintained without review and were furnished with acute bed complements greater than was considered necessary in most jurisdictions, with fewer community-based facilities and with restricted access to sub-specialty services. Some catchments, such as West Cork and Roscommon and the proposed new catchment of Tipperary North Riding with populations of around 50,000 were manifestly too small to provide comprehensive multi-specialty services. Thus, many catchments did not have ready access to the newer sub-specialties which a larger catchment would provide. These included, among others, conditions requiring a co-morbid intervention approach, such as psychiatric illness in the intellectually disordered and in substance abusers.

The Inspectorate was struck that little thought had been given to the implications and possible advantages to psychiatric care of the recent proposals on the restructuring of the health services. These included the recommendation of the Hanly Report that acute hospital services, including those for psychiatry, be located in about a dozen regional hospitals, with subsidiary and supportive crisis overnight arrangements provided more locally. A consideration of the two Hanly Pilot Areas — the East Coast Area and Mid-Western Health Boards, with respective populations of 320,000 and 340,000 (of whom approximately half would access private psychiatric care in the first instance) and actual or proposed acute psychiatric bed allocations of 128 and 110, in three different locations in each case — raised significant questions concerning acute psychiatric bed regionalisation and rationalisation in tandem with requirements for expanded and more sophisticated community service provision.

EXPERT GROUP ON MENTAL HEALTH POLICY

The Health Strategy “*Quality and Fairness — A Health System for You*” included a commitment to prepare a new National Policy Framework for the further modernisation of mental health services. To this end, the Expert Group on Mental Health Policy was established in August 2003. It is envisaged that the Expert Group will examine, *inter alia*, models of care, the respective roles of medication and complementary therapies, measures to reduce stigma and psychiatric services for specialised groups such as the homeless, prisoners, children/adolescents and those attending learning disability services. The Group consists of 18 widely experienced people who are serving in their personal capacity. The membership encompasses a wide range of knowledge and a balance of views on many issues affecting the performance and delivery of care in our mental health services. The Group is expected to consult widely with interested parties and report in 2005.

THE MENTAL HEALTH COMMISSION

Through the powers of the Mental Health Act, 2001, the Commission was established with effect from 5th April 2002. Its primary function is to promote and foster high standards and good practices in the delivery of mental health services and to ensure that the interests

of detained persons are protected. The Commission will arrange for an independent review, by a Mental Health Tribunal, of all decisions by a consultant psychiatrist to detain a patient for psychiatric care and treatment on an involuntary basis and each decision to extend the duration of such detentions. The Commission will be the registration authority for all hospitals and in-patient facilities providing psychiatric care and treatment.

The existing office of the Inspector of Mental Hospitals will be replaced with the office of the Inspector of Mental Health Services, who will be employed by the Commission. The Inspector will be required to visit and inspect all approved centres at least once a year. This new Inspectorate assumed responsibility for inspecting services on 1 January 2004.

EQUITY AND FAIRNESS

The contrast in conditions between private and some public accommodation gave grounds for concern. St. Patrick's Hospital, Dublin, an exclusively private hospital and the new ward in St. John of God, Stillorgan reserved for private patients only (the hospital also catered for some public patients), with their high standards, stood in sharp contrast, for example, to the Victorian realities of ward one, St. Bridget's Hospital, Ballinasloe. In the case of the new admission ward in St. Patrick's, the contrast with the acute admission wards of St. Brendan's Hospital, a few hundred yards across the Liffey, could hardly have been more striking and clearly brought into focus current inequities in our provision for the different social groups. The matter was put into even starker contrast when the reports from the National Psychiatric In-patient Reporting System of the Health Research Board, showing the far greater psychiatric morbidity of persons from disadvantaged social classes, were considered.

FUNDING ISSUES

It has become commonplace recently to complain that the proportion of non-capital funding that goes to psychiatric services on an annual basis has declined over the past decade. There has been a reduction from 13% in 1988 to under 7% in 2003. However, in absolute terms expenditure has increased from 165 to 612 million euros in the same time. It should, however, be borne in mind that in the financial year 1956/57 the proportion spent on mental health services was 19.5% and was to rise to 21.8% in 1960/61. At that time there were almost 20,000 public in-patients, who by 2003 had fallen to around 3,200. Given that in-patient care is the most costly element of provision because of 24-hour staffing, it is hardly surprising that costs should have fallen as inpatient numbers declined. As staffing costs are by far the largest element of non-capital expenditure, it is worth pointing out that nursing numbers, which comprise the largest component of staffing costs have, in the same time period, declined from approximately 7,000 to 5,000, while there have been considerable pay increases for all staff.

Looking at the needs of our mental health services more broadly, it is worth questioning whether our current non-capital expenditure is deployed efficiently particularly in the matter of staff location and function and in the face of increasing specialisation. It is clear, on the other hand, that there is a greater need for increasing physical resources to provide

mental health centres, day hospitals, more community-based residential facilities and to improve conditions in some of our residential and other premises. Indeed over recent years, despite the provision of substantial numbers of general hospital psychiatric units, capital spending on an average annual basis has been of the order of 2% of non-capital. How to increase the capital spend is one of the most pressing issues facing contemporary Irish psychiatry in the short- or medium-term. Innovative approaches such as action by voluntary effort and perhaps some public-private partnership approaches should be explored further. There is also the matter of realising capital assets such as land banks, considerable and valuable in many instances, such as at St. Ita's and St. Brendan's Hospitals and ensuring that the proceeds revert to the psychiatric services for capital development.

Within current expenditure, however, there are considerable disparities, which are historical rather than based on any rational or epidemiological considerations. Thus some catchment areas with relatively few medical card holders, where most of those seeking psychiatric care do so in the private sector, are relatively lavishly funded, compared to others where there are few subscribers to private health insurance and much deprivation. These circumstances are particularly evident in the Dublin area.

INPATIENT BLACK SPOTS

Despite the considerable progress that has been accomplished in replacing or improving inpatient premises, there were still some locations that were unacceptable for care and treatment of patients because of seriously unsatisfactory conditions. These included:

- Most of the Central Mental Hospital
- The entire St. Brendan's Hospital
- Almost all of the old building at St. Brigid's Hospital, Ballinasloe
- Some long-stay wards in St. Finan's Hospital, Killarney
- St. Edna's and the current female admission wards in St. Loman's Hospital, Mullingar
- The admission wards at St. Ita's Hospital, Portrane
- The female admission ward at St. Senan's Hospital, Enniscorthy
- Vergemount Clinic, Dublin
- Some continuing care wards at St. Luke's Hospital, Clonmel and
- Some wards at St. Joseph's Hospital, Limerick

In addition, some relatively recent acute units did not provide safe observation facilities, such as at St. James's Hospital, Dublin and at Limerick Regional Hospital. Some of the smaller private hospitals catering for elderly patients were unsuited for this purpose because of the structure and layout of the premises, with many small rooms spread out over several floors.

SERVICE DEFICIENCIES

There were gaps in provision for specific groups of persons and among these were services for:

- The homeless
- Prisoners and others coming into the ambit of the criminal law
- Emigrants and asylum seekers
- Mental Health in primary care
- The co-morbidity of intellectual disability and psychiatric illness
- The co-morbidity of substance abuse and psychiatric illness

In addition, further strengthening of child and adolescent, forensic and later life services were required both in themselves and in their relationship with general adult psychiatry.

ACUTE GENERAL HOSPITAL UNITS

It has long been a central element of policy that inpatient treatment for acute psychiatric illness should be provided in general hospitals. As indicated earlier, considerable progress had been made towards this aspiration. Nevertheless, there were still, in 2003, patients being treated for acute illness in single specialty psychiatric hospitals, including the entire acute private sector. Despite this, there were at the end of the year 21 general hospital units operating, including two that had opened during the year.

The first of these was at St. Luke's General Hospital, Kilkenny for the Carlow/Kilkenny Mental Health Service to replace admission units at St. Canice's, Kilkenny and St. Dymphna's, Carlow. This 46-bedded unit also provided an acute assessment component for the psychiatry of later life. This represented a significant step towards the closure of the two psychiatric hospitals both of which continued to accommodate long-stay elderly patients.

The acute admission unit at Castlebar General Hospital opened late in 2003; its 44 beds will cater for both general adult and later-life psychiatry assessment purposes. The unit replaced the St. Teresa's Unit on which re-modeling had already begun to convert it to a rehabilitation facility. Within days, the new high-support rehabilitation residence in Castlebar had also opened.

As was now customary neither unit opened without prolonged management/union negotiations.

At Portlaoise, the new psychiatric unit in the general hospital had been ready for psychiatric occupation for over 18 months, but had been requisitioned by the medical department while improvements were being carried out to their own accommodation in the hospital. Our information at the end of the year was that the unit would be vacated by the medical teams and be handed over to psychiatry by the end of March 2004. Thereafter, some minor redecoration would be necessary before this 50-bedded unit with its acute

assessment facility for the elderly would receive its first patient, whereupon the two current admission wards in St. Fintan's Hospital dating from the mid 19th century would close.

At James Connolly Memorial Hospital, Blanchardstown the new psychiatric unit was completed by the middle of 2003. Unfortunately there were some difficulties in relation to internal spatial matters, particularly in the dining areas and, in addition, the internal courtyard was overlooked by other components of the hospital on the floors above, thus compromising patient privacy. However, by the end of 2003 these issues were being attended to and the aspiration was that the unit would be up and running early in 2004. This was essential to enable the current acute unit, unsatisfactory in all respects, to close. The new unit, in addition to providing for general adult psychiatry, also had sub-units for assessment of the elderly and for presenile, or less pejoratively, younger persons with organic brain disorders.

The new unit at St. Vincent's Hospital, Elm Park, built to replace the totally inadequate premises at Vergemount Clinic and to provide for catchment Area 2, was complete and ready to operate by the end of 2003. Unfortunately, the necessary and usually prolonged management/staff negotiations involving both St. Vincent's Hospital and the East Coast Area Health Board had not concluded.

Elsewhere, progress had been slow or non-existent. The planning of the Sligo unit, which the Inspectorate had understood to have concluded in 1992, had been revisited by local professionals leading to a considerable and, in the view of the Inspectorate, unwarranted enlargement of the original design. This had resulted in the project, as originally agreed, being no longer fundable in the present economic climate and condemned patients to the unsatisfactory current admission unit in Ballytivnan. No progress had been made in relation to the planning of a unit in Portiuncula Hospital, Ballinasloe, to replace the existing admission unit at St. Brigid's Hospital, although meetings on the issue had taken place between the relevant bodies before Portiuncula Hospital was taken over by the Western Health Board. Since then, no further action on the matter had resulted. Critically, this initiative, should it take place, would bring the cultural and attitudinal change necessary to shift thinking in the East Galway service towards a community-delivered service and lead to the closure of St. Brigid's Hospital. Meantime, the existing admission units at St. Brigid's Hospital had been upgraded in what could only be regarded as a stopgap measure.

A similar stopgap arrangement was being put in place at St. Loman's Hospital, Mullingar with the refurbishment at considerable cost of the admission unit, when the appropriate response would have been to provide an admission unit in Mullingar General Hospital, or more innovatively to deploy the 50-bedded unit at Portlaoise to serve the entire Midland Health Board's four counties. The quite unsatisfactory admission arrangements at St. Senan's Hospital, Enniscorthy underline the necessity for the urgent provision of an acute unit at Wexford General Hospital or a shared arrangement, along the lines of the Portlaoise proposal. The psychiatric unit in Letterkenny General Hospital needed improvement and extension.

THE CENTRAL MENTAL HOSPITAL

The Inspectorate had year-on-year, described the intolerable conditions that pertained in parts of this hospital. In 2002 a Working Group had been set up to review the future of the Hospital and had reported. In 2003 a Project Group had been put in place to move matters forward in relation to the medium- or long-term plans for the hospital, whether to replace it on another site or otherwise. In the meantime, capital monies were set aside in 2004 to improve matters on an interim basis. Obviously more fundamental and radical measures will be required to improve matters more widely and end “slopping out”. In addition, a report of a Working Group recommended the funding of a service level agreement between the East Coast Area Health Board and the Irish Prison Service aimed at improving services to mentally ill prisoners and in accelerating their transfer to and treatment in the hospital.

The Inspectorate noted that Section 208 of the Mental Treatment Act, 1945 continued to be used for the transfer of “difficult to manage cases” to the Central Mental Hospital, an institution conceived and established for the care of mentally ill persons from the criminal justice system. It was the Inspectorate’s view that such transfers were stigmatising and inappropriate and that the only reason that they took place was because there were no regional intensive care facilities available nor, until recently, any rehabilitation teams in local services. However the provision of regional intensive care units had now become a priority and specialised rehabilitation teams were now being set up.

CRIMINAL LAW INSANITY BILL, 2002

This Bill, which was designed to amend the law relating to the trial and detention of persons suffering from mental disorders who are charged with offences or are found not guilty by reason of insanity, introduces the new concepts of fitness to be tried and, in the case of murder, of diminished responsibility by reason of mental disorder, into Irish law. In addition, the courts will have power to make orders sending persons to designated psychiatric centres and will establish Mental Health Review Boards to review the case of persons who are the subject of such orders. There is also provision for mentally ill persons who have come into the criminal justice system to be deviated to local psychiatric services rather than be convicted and sentenced to prison.

The Bill was introduced to both Houses of the Oireachtas during the year and further steps toward its enactment were awaited. This legislation however, does not provide for persons transferred from prison who are deemed to have become mentally ill while serving a sentence or on remand and transferred to the Central Mental Hospital under a Hospital Order or a Ministerial Order as provided for by earlier legislation. Such persons have no right of appeal to the Mental Health Review Board as provided by the Bill and therefore their detention will not be subject to any independent review process, almost certainly in contravention of international human rights charters.

With regard to the Bill itself, the Inspectorate had some reservations in relation to the definition of mental disorder, which differed from that used in the Mental Health Act, 2001, and also in the restriction in the Bill to the order for assessment and treatment being

made to in-patient locations exclusively. Another matter that arose during the year and that caused some concern to forensic teams at the Central Mental Hospital was the discovery that the Immigration Act, 1999, which became effective in 2002 and gave powers to the Garda Síochána to make Authorised Person Orders and listed places where persons might be detained under such Orders. Among these was the Central Mental Hospital. The concern was that there had been no consultation with the Department of Health and Children in the matter and that a Garda could make an Order to the Central Mental Hospital without any psychiatric consultation. Furthermore, as matters stood, there was no protection or relief available under the Act to persons detained under these powers.

MENTAL HEALTH SERVICES AND THE GARDA SÍOCHÁNA

Previous reports had spoken of the need for greater co-operation between local mental health services and the Gardai. In pursuit of this, the Garda Training College had introduced a mental health awareness module into its training course with the involvement of the Inspectorate. Consultation with the Garda training personnel had made clear that there was still a long way to go to dispel mutual distrust between psychiatric service providers and the Gardai in relation to having both sides working harmoniously and productively together. Gardai instanced that, having sought help for mentally ill persons they encountered, their efforts to seek care for such persons were often rebuffed on such grounds as residential legitimacy for a catchment area or homelessness. It is to be hoped that much more consultation and co-operation will take place locally on this issue. An expanded specialist forensic service and the proposed Criminal Law Insanity legislation should act as catalysts in improving matters.

TRANSFER ARRANGEMENTS

The practice of transferring patients from acute psychiatric units to the psychiatric hospital in the same catchment area was prevalent in some services. This occurred either because there was no vacancy in the psychiatric unit to accommodate a new admission or because patients were considered too disturbed to be cared for in the general hospital unit. Such patients were usually re-transferred in the opposite direction when a bed became available or when the acute phase of disturbance had passed. The Inspectorate was concerned about this practice on two grounds. Firstly, the legal requirements of the Mental Treatment Act, 1945 were usually not adhered to in these transfer arrangements. It should be realised that both the general hospital acute unit and the mental hospital have independent legal status, the first as an approved institution and the second as a district mental hospital. Therefore, before a transfer can be undertaken a patient must be discharged from one before being admitted to the other, except in the case of detained patients transferred under the provisions of sections 206 or 208. Not to comply with these obligations is both illegal and administratively confounding, as patients may in these circumstances, be discharged from hospitals to which they were never legally admitted or never discharged from a hospital to which they were admitted.

The second cause of concern was that very often patients transferred had not been fully informed of the impending transfer, the reason for it, nor had their informed consent to the transfer been requested. Additionally, the transfer arrangement itself had sometimes

been careless in the detail of the procedure and, in some cases, dangerous. For instance, in one jurisdiction patients were regularly transferred unaccompanied, by taxi, without adequate, or any, accompanying clinical documentation, at short notice and late in the day. In the case of the first reason for transfer, the shortage of beds had usually resulted from absence or non-enforcement of an admissions policy or an inadequate or non-existent system of bed management compounded, in some instances, by a lack of community-based alternatives to admission. In the second instance, there was often a reluctance to engage with difficult clinical management situations, although, it must be said, in mitigation, that some acute units did not have adequate close observation areas and, for more serious disturbance, the lack of regional intensive care units was an obvious shortcoming.

While pointing out these general practices it is necessary to highlight examples which were particularly worrying and where the matter was more widespread. Firstly, there had been a long-established practice of transferring patients from the unit at Galway University Hospital to St. Brigid's Hospital, Ballinasloe, in addition to directing some patients there from the unit without admitting them in the first instance, a practice that the Inspectorate had adverted to in many previous reports. Secondly, and more recently, was the concern that, with the remodeling and reopening of the former St. Anne's Unit at Shanakiel, Cork, renamed Carraig Mór, as an intensive care and rehabilitation facility, substantial numbers of patients from all four Cork services were being transferred there without the correct legal formalities being adhered to.

PSYCHIATRIC DAY CARE

Following a study in two health boards on the appropriateness and utilisation of current day care provision, the Health Research Board had published, in 2003, a report *Psychiatric Day Care — An under used option?* on the purpose and function of psychiatric day hospitals and day centres. The results of the study revealed that many day hospitals and day centres were located in inappropriate premises with some patients spending long hours travelling to and from these facilities. In addition, the study showed that more seriously ill patients were generally not dealt with in day settings, even when this would have been appropriate as an alternative to hospitalisation. Furthermore, many day premises were poorly designed to serve as acute day hospitals with inadequate space to accommodate and deal with disturbed patients. There was a broad understanding on the part of staff of the different roles of day hospitals and day centres but differences emerged in staff awareness of which patients were appropriate for care and treatment in day hospital settings. The report contained conclusions, guidelines and recommendations in relation to future development of these services.

DEPENDENCY IN COMMUNITY RESIDENCES

The Inspectorate had been struck by how little rehabilitation took place in community residences and how their management was oriented towards continuing, rather than decreasing dependency. Many were over-staffed, patients were not encouraged to take on the management of these, their homes, did not take charge of domestic matters such as paying their own expenses for light, telephone, heating accounts and so on. Many were staffed at a level of skill far beyond that required, such as having nurses sleeping over, i.e.

being on duty at night needlessly, and with little by way of training or occupation available during the day. It was little wonder then that some community residences or hostels are referred to as “mini institutions in the community”. The matter was to be the subject of a research project by the Health Research Board, supported by the Mental Health Commission, in its on-going programme of mental health service research.

THE INTELLECTUALLY DISABLED IN PSYCHIATRIC HOSPITALS

Despite some progress in transferring intellectually disabled persons from unsatisfactory and unsuitable accommodation in psychiatric hospitals to more appropriate specialised settings, significant problems remained. Intellectually disabled persons still remained in St. Senan’s Hospital, Enniscorthy, St. Luke’s Hospital, Clonmel and St. Brigid’s Hospital, Ballinasloe. Despite the movement of some such persons from St. Joseph’s Hospital, Limerick to specialised services at Lisnagry, some still remained in that hospital. In some cases, most noticeably in St. Luke’s Hospital, Clonmel, such persons were mixed indiscriminately with functionally psychotic patients, some newly admitted. The largest number of intellectually disabled persons was in St. Ita’s Hospital, but this was in the separate St. Joseph’s service.

THE HOMELESS MENTALLY III

Homelessness remained a problem for many mentally ill persons, leading to neglect, premature mortality, delayed or absent treatment, unnecessarily prolonged in-patient stay and frustration for all concerned. There was a reluctance to take responsibility for such persons because of the difficulties in effecting discharge. Although it was difficult to establish with scientific accuracy the extent of the problem, it was clearly substantial in the Dublin area and also present to a lesser extent in other metropolitan areas, often compounded by the co-morbid problem of substance abuse. An adequate response to it was awaited. In Dublin, there were two consultant posts for the subspecialty, based in a sub-standard and unsatisfactory unit at St. Brendan’s Hospital in which almost all residents were long-stay. There were virtually no outreach services. The one consultant in post, who did not have a specialised team, was about to retire and the second post remained unfilled almost two years after being created. However, the Area 3 service had recruited a part-time consultant for homeless mentally ill and the Area 2 service was attempting to provide a limited service for the homeless in its area. It was clear that there needed to be a concerted, global, integrated and coordinated response of multidisciplinary nature to the problem, which was currently lacking.

CHILD AND ADOLESCENT PSYCHIATRY

The Inspectorate had limited contact with the facilities and personnel of this subspecialty because of the virtual absence of residential facilities. These services, seriously neglected for so long, had substantially improved in recent years and at the end of 2003 there were 39 specialist teams operating. Not all were well resourced from the point of view of multidisciplinary and some were unhappy that administrative arrangements were isolating them from general psychiatric services. However, on one point there could be no disagreement, and that was that the virtual absence of in-patient residential places for children and adolescents was a serious national shortcoming. The consequences were serious, not

alone for these services, but also impinged on the adult services as instanced by the case of the acute general adult unit in the Regional Hospital Limerick referred to below. In June 2003, the Working Group on Child and Adolescent Services produced its Second Report. Among its recommendations were that mental health services should be developed to meet the specific needs of the 16 — 18 year old group and that in each health board, child psychiatrists with a special interest in the psychiatric disorders of later adolescence should be recruited.

Because there was very limited in-patient provision for children nationally, there had been instances of children being admitted to and retained in adult units. This had been particularly the case in the psychiatric unit in Limerick where, at the time of inspection and more generally, there had been three children, one as young as 13 years on the unit; in addition, one of these youngsters had been there continuously for over a year. Apart from the evident unsuitability of this there had been serious knock-on effects. It had been the policy that these children had one-to-one nursing on a 24-hour basis which the service felt it had a legal obligation to provide for reasons of safety and for the protection of the children concerned. As well as the substantial cost of this measure, there had been consequences for the rest of the patients. It had been felt necessary, in order to contain the children, in addition to the special nursing arrangement, to keep the unit doors locked at all times, thus restricting the freedom of all other patients on the unit.

THE PSYCHIATRY OF INTELLECTUAL DISABILITY

Among the specialties requiring development was the specialised care of psychiatric disorder in the intellectually disabled. Historically, services for the intellectually disabled, mostly provided by voluntary initiative, grew independently in institutions isolated from mainstream psychiatry and employed their consultants from this perspective. A more community, catchment-based orientation was now required to ensure that community-living persons with this disability obtained appropriate and specialised treatment for co-morbid psychiatric disorder. Therefore, consultants and their teams in this subspecialty needed to be deployed or recruited on a catchment area basis, should be recognised and integrated as members of that catchment area psychiatric team and have access to all its facilities, including acute in-patient care in acute psychiatric units, when that setting is deemed appropriate. It is essential in this arrangement that the consultants in this specialty should care for their own patients. On the facilities side, there was a clear requirement for specialised units for challenging behaviour with co-morbidity with specialised staff to deal with the substantial extent of mental illness encountered in those intellectually disabled.

MENTAL HEALTH IN PRIMARY CARE

Since the 1966 Commission on Mental Illness Report, greater involvement of primary care in detecting and treating psychiatric illness had been a major, but generally unachieved, aspiration. Among other benefits this would help to ensure that out-patient and other psychiatric services served a secondary referral and consultation function rather than as maintenance services. The impediments to this ambition had included both the organisation and funding of general practice and the access to medication. By and large, there had been little endeavour on the part of psychiatric services to involve primary care in

setting up models of joint working, with the exception of an innovative and useful initiative in the East Cavan sector. With the publication of the Primary Health Care Strategy it seemed that now was the time to establish similar initiatives in other parts of the country. A survey of the services delivered to persons with psychiatric disorders by primary and psychiatric care was completed under the auspices of the College of General Practitioners and the South Western Area Health Board — *Mental Health in Primary Care* — by Mimi Coptý and published in 2003. However, it did not address the fundamental issue of service organisation.

THE PSYCHIATRY OF CO-MORBIDITY

The co-morbidity of mental illness and intellectual disability has already been considered under its own heading. However, the co-existence of psychiatric illness and substance abuse and dependence has now become a major factor presenting to services and in the homeless. However, the services in this country for substance abuse are dichotomised into those that deal with alcohol, and those concerning themselves with non-alcohol drugs. It seemed to the Inspectorate that this was a false distinction on two grounds: first because the phenomena of abuse and addiction or dependence are the same for both conditions and ordain generic conceptualisation of the problem and the approach to it, and secondly, because it is becoming less common to encounter abuse or addiction of “pure” kind to one substance only. Hence, the case for a combined service appeared clear. This combination approach applied not alone to the substances but also to co-morbid psychiatric illness. A number of approaches to the best service model to bring to bear on the problem had been suggested, varying from combined to single or specialised co-morbid team initiatives. In any case, the matter was now of sufficiently wide impact to require a planning and delivery response.

ENQUIRIES

The Inspectorate was directed by the Minister for Health and Children to enquire into the deaths of two persons contacting or in psychiatric care during the year. The Inspector’s Report in the first case contained recommendations that were forwarded to the relevant service providers. The second case was still under enquiry at the end of 2003.

SUDDEN DEATHS

Under the provisions of section 272 of the Mental Treatment Act, 1945 all deaths of inpatients are required to be reported to the Minister. During 2003, there were 19 sudden or unexplained deaths of inpatients occurring in hospital premises or while on leave, (whether with or without permission). All were reported to the coroner and all were the subject of post-mortems. Those not found, on the basis of post-mortem, to be from natural causes were, or will, be the subject of inquest proceedings.

Of the 19 such deaths, 15 were deemed on clinical grounds to be suicide or suspected suicides. Eight of these latter were male; seven were on leave — four without permission and one on accompanied leave visiting an external hospital. Three were in the private sector. Three inpatients died from causes that may have been drug related. One of these

was associated with the gastro-intestinal effects of one of the newer atypical anti-psychotic drugs and the remaining two from sudden cardiac deaths, deemed by the pathologist likely to have been from cardiac arrhythmias, possibly related to current medication.

SMOKING REGULATIONS 2003

In 2001, the Inspectorate issued a letter to all in-patient units and community residences requesting the acceptance of the principle that all such premises should be non-smoking but that specific arrangements be made for smokers. These comprised the setting aside of parts of accommodation as designated smoking areas outside of which smoking was to be prohibited and urged staff to ensure that these regulations were enforced. In addition, the Inspectorate recommended that the existing practice of some hospitals in distributing tobacco products to wards on a weekly basis should cease and services should make available smoking cessation programmes to patients. Some units and hospitals, in common with other institutions and workplaces, had provided separate external accommodation for smokers in igloo shaped pavilions which were functionally, as well as aesthetically, pleasing. The Inspectorate was unhappy that the Smoking Regulations which banned smoking in health settings had excluded psychiatric hospitals. It was felt that this exception was discriminatory and stigmatising.

ADMINISTRATION, PLANNING AND GOVERNANCE

The Inspectorate had in some cases been struck by the poor quality of service planning, both at health board and individual service level. While there had been obligations on health boards to produce one year service plans and longer outcome projections, these had sometimes been relatively cursory and unimaginative and had not been driven by frequent reviews and assessments. In some cases, no or irregularly held meetings occurred, or were conducted in a most un-businesslike fashion as if the participants had little belief in their purpose or outcomes. Matters had not been helped in that the atmosphere between senior executive and first-line service providers had sometimes been one of mistrust, particularly in a perceived lack of budget transparency. All this had hindered progress and had had a discouraging effect on some service providers.

It seemed appropriate to recall the example of the East Galway service referred to in last year's report where local senior management found themselves disempowered and unable to deal with the unsatisfactory conditions prevailing in St. Brigid's Hospital. So bad were matters that the Inspectorate felt obliged to make a special report to the Minister for Health and Children which led to the setting up by the Western Health Board of a "Reshaping Group" for the East Galway service with a wide representation and many sub-committees under a facilitator in an attempt to move matters forward. The depth of the difficulties may be gleaned by the fact that after 12 months the Inspectorate was given to understand that the Group was less than half way through its work.

Senior clinicians working in the Eastern Regional of Health Authority had complained to the Inspectorate of how uninformed, frustrated and remote from "the action" they felt, in not alone having to go through their own constituent Health Boards, but then having

to deal with the ERHA, in relation to planning and service improvement issues. All felt that these tribulations were not in accord with the much vaunted “partnership” approach to working together.

CARE PLANNING AND DOCUMENTATION

Once more, the Inspectorate wishes to comment on the general lack of a clearly delineated and annotated treatment plan for each new patient entrant to services in which the patient and carers are participant partners. There appeared to be a lack of understanding that the clinician/ patient relationship was essentially a partnership towards a common and shared goal of treatment that had to be open, informative and transparent. Case note and other documentation often gave little indication that the necessary transactions underlying this process had taken place. On a more prosaic level, there were often serious deficiencies in case note design, structure and maintenance and recording such that it was sometimes impossible to derive a patient’s legal status or whether a detention had been renewed, from the record. A reluctance to append a classifiable diagnosis, a treatment plan and periodic review were often also evident.

RISK ASSESSMENT AND MANAGEMENT

As mentioned in previous reports and in the Guidelines on Good Practice 1998, the Inspectorate had emphasised the importance of clear policies, procedures and guidelines to protect both patients and staff, and the need to introduce a monitoring process to ensure that policies were adhered to. The Inspectorate, over the years, had recommended that all services adopt a stringent and proactive risk management culture. By addressing the risks identified, together with control mechanisms, services would improve the quality of care provided and reduce the level of risks to patients, staff, the health boards and the general public. The standard of risk assessment and management across the country was variable. Ideally, while all managers should have carried out risk assessments in their area of responsibility; some health boards had delegated this responsibility to regional health and safety managers who visited periodically and produced reports. While this was welcome there was a need for shared ownership of accountability and responsibility.

CLINICAL AUDIT

Not all services had well established and comprehensive arrangements for the selection of clinical audit topics or the reporting of audits undertaken and the monitoring of their follow-up. There were a few notable exceptions where an audit culture had developed and audit findings had resulted in changes in practice. Comments on the presence or absence of clinical audits have been made in individual service reports. The Inspectorate noted that formal auditing processes did not generally take place following suicides and encouraged services to introduce them.

PROVISION OF INFORMATION

Information leaflets or booklets were available in most admission units and many of the community facilities visited had statements of purpose and function prominently displayed. The Inspectorate, on service visits, interviewed patients, selected at random, and

most gave positive feedback on the care provided. Interviewees however, were less satisfied with information of a more general nature given to them. Many were unaware that they had a care plan, were uncertain about their rights under the Mental Treatment Act, 1945 and how to use the local complaints procedure should they need it.

ADVOCACY

In recent years, some service providers had taken steps to ensure that a system was in place to seek feedback from patients on the quality of care provided. This was an encouraging development. Advocacy schemes had been established in a number of health boards and although very much in their infancy appeared to be working well.

TASK FORCE ON ASSAULTS ON PSYCHIATRIC NURSES

The Minister for Health and Children had established a Task Force to investigate assaults on psychiatric nurses with a view to exploring preventative measures to reduce the incidence of assaults and, where assaults had resulted in serious physical or psychological injury, to provide a compensation scheme. The Task Force completed its work in April 2003 and submitted its Report to the Minister. The Minister has sought a compensation scheme for state-employed psychiatric nurses seriously injured as a result of assault during the course of their duties. The scheme envisaged will be a no-fault, non-statutory scheme.

ELECTRO-CONVULSIVE THERAPY

While the administration of ECT had greatly decreased, there remained considerable variation in its prevalence from service to service. The Inspectorate monitored the use of this treatment and the facilities for its provision; deficiencies noted in facilities or in current practice were highlighted in individual reports.

SPECIAL NURSING OBSERVATION

The Inspectorate monitored the use of special nursing supervision and nursing observation levels. Comments and recommendations were included in each individual service report. Statistical data relating to one-nurse to one-patient special nursing supervision by hospital and health board is included in the tables at the appendix to this report. Special one-to-one nursing supervision was usually initiated and discontinued on the written instructions of the patient's consultant psychiatrist and occurred primarily because of assessed significant risk of self-harm or harm to others.

SECLUSION

The Inspectorate monitored the use of seclusion by examining seclusion policies, procedures and guidelines, seclusion registers, medical and nursing records relating to seclusion episodes and visited each seclusion facility on the day of inspection. It was noted that some hospitals did not use seclusion and many had reduced its use significantly. Statistical data relating to seclusion by hospital and health board is included in the appendix. It was the Inspectorate's view that seclusion should only be used as a last resort to contain severely disturbed behaviour, likely to cause harm to others, and for the shortest time possible.

ACCIDENTS, INCIDENTS AND ASSAULTS

Due to the fragmented approach to the recording of health and safety issues in a number of hospitals, and drawing on practice in private hospitals, the Inspectorate gathered information on accidents, incidents and assaults on a more formal basis. The aim of the Inspectorate was to encourage hospitals and service managers to collect this information, with a view to tracking and trending all accidents, incidents and assaults by date, time and location. This was intended as a first step in developing prevention strategies. In latter years, these were classified by grade of injury. Details of recorded accidents, incidents and assaults were included in individual service reports. The reported incidents might appear greater in the private hospitals but this was due to more sophisticated reporting systems. It was noted in some services that, following serious incidents, reflective meetings took place.

CLINICAL TRIALS

On each inspection, the Inspectorate enquired into any research being carried out governed by the Clinical Trials Act 1987-1990. Under the provisions of the Mental Health Act, 2001, detained (involuntary) patients cannot be subjects in drugs trials. Our enquiries indicated that there had been three drug trials carried out in the Irish psychiatric services in 2003.

CLOSED CIRCUIT TELEVISION (CCTV)

The Inspectorate was of the view that the use of CCTV to monitor patients was a serious invasion of personal privacy and dignity. The Inspectorate had no objection to the use of closed circuit television as a safety device in seclusion rooms, provided observations were carried out and recorded according to the regulations as set out in the Mental Treatment Act, 1945. However, it should never replace the clinical skills of personal observation, which necessitated human interaction between patients and staff which was in itself therapeutic. The Inspectorate conceded that the use of CCTV at the entrance to admission areas might be useful as a safety device for patients and staff but where used, notices informing the public of its use should be prominently displayed.

HOSPITAL CHARGES AND MONEY MANAGEMENT SYSTEMS

In the course of inspections, patients' personal money management systems were examined. Generally, service providers ensured that patients controlled their own money except in particular circumstances where they did not wish to or lacked the capacity to do so. In such cases, appropriate safeguards were in place to protect their interests. Written records of all transactions were maintained, secure facilities were provided for the safekeeping of money and valuables and records and receipts were kept of monies handed over for safe keeping and monies withdrawn for personal spending.

ACCESS TO FRESH AIR AND OPEN SPACE

Access to fresh air is a basic human need and is required to be taken very seriously by hospital service providers. While in most services this was not an issue, in a small number of units patients' access to fresh air remained a problem and this was commented on in individual reports.

LOCKING OF WARDS

Patients requiring admission to hospital should be treated in the least restrictive environment, with minimum disruption to their lives. The frequency of locking external ward doors on non-secure wards was a matter of concern to the Inspectorate. Recommendations were made that service policies on the locking of external ward doors be available and that compliance with the policy regularly audited.

PATIENT ACTIVITIES

On a number of visits, patients were observed sitting in lounges or in dormitory areas with little activity. Patients interviewed often complained of being bored, especially at weekends when there was nothing to do except smoke and watch TV. All patients should be made aware of recreational activities on offer in the in-patient care areas and encouraged to participate as part of their care plan. Standards in some services in this regard were high, especially where a nurse was assigned as an activities co-ordinator or occupational therapists were employed. Other services needed to pay more attention to this matter in order to respond appropriately to patients' needs.

PROTECTION OF THE CONSUMER, INFORMATION, COMPLAINTS AND RIGHTS UNDER MENTAL HEALTH LEGISLATION

All services visited had an adequate complaint or dissatisfaction procedure available to patients and notices to this effect were prominently displayed. In addition, all services had notices informing patients of their rights of appeal under the Mental Treatment Act, 1945 and amending legislation. However, it was not clear from talking to patients and from an examination of clinical notes if there was a robust system in place for bringing this information to the attention of patients. It was recommended that a standardised form be used to record that this information had been given.

TRAINING IN EMERGENCY PROCEDURES

The Inspectorate had concerns related to unregulated training courses on the management of aggression and violence. The Inspectorate recommended that a set of approved national training standards be developed and validated by a training authority, in order to ensure uniformity of approach throughout the country. The nursing/midwifery planning and development units and the recently established centres for nurse education should take a lead role in this regard. Similar approaches should be used for cardio-pulmonary resuscitation and foreign body airway obstruction training in order to bring some structure to the training and skill required in these important health and safety interventions.

TRAINING OF PSYCHIATRISTS

With the re-organisation of health structures, the Post-graduate Mental and Dental Board will be abolished. The future home of the various specialty training bodies in medicine is unclear at the time of writing. In the case of psychiatry this has been the Irish Psychiatric Training Committee which has functioned to implement the training programme of the Royal College of Psychiatrists of the United Kingdom, a body with no legal status in this jurisdiction. However, the College inspects, unilaterally, Irish psychiatric services, in

accreditation for its training process. The reports of such visits sometimes have implications for our services. During the year, the Inspectorate was made aware that training approval might be withdrawn from the services of the Mid-Western Health Board because the Psychiatric Unit in Limerick Regional Hospital was admitting children. While the College had the right to determine the rules and circumstances of training in its own jurisdiction, to so dictate, with such serious consequences for Irish services highlights the deficiencies of the current arrangements.

Now, with the responsibility for training passing from the Post Graduate Medical and Dental Board to the Health Services Executive, and possibly to a Central Training Authority or similar body as recommended by Hanly, the Inspectorate is of the view that this is the time to end the manifestly unsatisfactory training situation and establish a national Irish training programme. There are five Irish medical schools and a greatly enhanced number of academic staff who should see it as their responsibility to establish such a programme, leaning perhaps, in the earlier years, on the existing programme but adapting it to national need and circumstances.

NURSING

The Nursing Education Forum Report of 2000 recommended that An Bord Altranais, as the regulatory authority, impartially and without prejudice undertake further research to examine the rationale for and impact of maintaining three points of access (i.e. general, mental handicap and psychiatric) to pre-registration nursing. This was required as part of an overall review of factors impacting on recruitment into nursing. An Bord Altranais have examined the historical issues that led to the distinct entry points of access and at the time of writing were consulting with, and obtaining the views of all key stakeholders. The Inspectorate welcomed this new initiative as it should be possible as heretofore for nurses to move within the various specialities in the wider nursing domain. The present system where a nurse opts for one speciality and cannot move to another speciality without undertaking the full pre-registration course is not sustainable and has contributed to recruitment difficulties because general nurses and mental handicap nurses can no longer undertake a shortened pre-registration programme in psychiatric nursing and vice-versa.

In relation to post-registration psychiatric nursing education, there is requirement for curriculum development in line with service needs. There is an urgent need for psychiatric nurses to become more involved in community services, early intervention, assertive outreach, active rehabilitation and in primary prevention. In the early days of this Inspectorate, the need for a manpower planning exercise to ensure mental health services recruited and trained an appropriate number of nursing and allied personnel to meet the demands of a mental health service in transition from largely institutional care to a community-oriented service was highlighted.

In July 2002, the Minister for Health and Children published the final report of the nursing and midwifery steering group entitled "Towards Workforce Planning" which noted that half of the qualified psychiatric nurses were aged 45 years or over, and projecting forward to the year 2007, that over 65% of psychiatric nursing personnel would be aged 45 years or over and only 14% under the age of 34 years. With the retirement age of 55 years

possible for the majority of psychiatric nurses this is a matter of concern for mental health service providers. Also during 2002, the government approved a sponsorship scheme for experienced care assistants with up to 40 sponsorships available. Successful applicants continue to be paid their normal salaries throughout the four years of the new degree programme in return for a commitment to work as nurses in their health service agency for a period of five years following completion of training. This new sponsorship scheme was reviewed during 2003 and the entry requirements relaxed. This new initiative developed in an attempt to recruit and retain nurses in our public health care system is welcomed.

SOCIAL WORK, PSYCHOLOGY AND OCCUPATIONAL THERAPY

Training bodies exist for this group of clinical professionals and this Inspectorate does not think it appropriate to comment on their suitability for practice in our mental health services. However, there has been difficulty in recruiting personnel from these disciplines to psychiatry. In part this has been due to the shortage of training places available, particularly in clinical psychology. Additionally as minority professionals, numerically, some felt professionally isolated and their functions and roles little understood and appreciated and so did not favour a career in psychiatry. The consequence had been that it has in many services been difficult to maintain multi-disciplinary teams.

OVERVIEW OF REGIONAL SERVICES

EASTERN REGIONAL HEALTH AUTHORITY

This composite body comprised three health boards whose services are reviewed individually. Within the general region and in individual health boards there were sometimes turf wars in relation to geographic responsibility. In addition, the problem was exacerbated by the presentation of homeless persons to services. Some services denied responsibility for persons whose care they had managed for many years but who had drifted out of their original catchment area through becoming homeless. Such persons, in the absence of comprehensive services for the homeless, went untreated with their condition worsening.

SOUTH-WESTERN AREA HEALTH BOARD

In the Area 4 and 5 service a plan to transfer some of this catchment to Area 3 was in the process of being worked out at the time of inspection but had not been finalised at the end of 2003. In mid 2003, the new rehabilitation and administrative unit opened at St. Lomans and at the same time all the clinical areas of the original hospital were demolished. The former staff homes on the campus continued to provide continuing care for the elderly. However, the plan was to relocate these patients to nursing home care, demolish the buildings and sell off the remainder of the site except for the new rehabilitation structure and a small portion of retained land. A new day facility to replace that in the former Glen Abbey building in Tallaght had been instituted on a rental basis in an office complex adjacent to Tallaght Hospital. A house in Newcastle, Teach Bán, for high-support residence, was being commissioned for residential occupation. The six-bed acute assessment

unit for later life psychiatry in the Tallaght Hospital acute unit had not opened but was in use for a very limited day care operation.

The Area 3 service was arranging to take over 40,000 population from the Area 4 and 5 service. Apart from this, the new sector headquarters and day service was beginning operation in the St. Monica's house on the North Circular Road, although the premises was not spatially well adapted to provide for acutely ill day patients. It was to serve the Camac sector. No equivalent initiative was in sight for the second sector, called Owendoher. The acute unit at St. James's Hospital served a variety of functions, none of them satisfactorily. The former 34 beds allocated by the hospital for continuing care purposes to the general adult service, had also closed with the transfer of these now elderly persons to smaller private hospitals or nursing homes. The day hospital for the later-life service, the Martha Whiteway, remained in St. Patrick's Hospital, although the plan was to transfer it to St. James's Hospital.

The Kildare/West Wicklow service had overcome its acute bed crisis by the opening of the high-support facility, The Brambles, at Newbridge. The house at Castledermot had not converted to the residential function for which it was ideally suited on the spurious grounds that it was "too isolated" despite being within a few hundred yards of the town centre. A large house on the edge of the Curragh had been acquired for housing purposes but funds were awaited to convert, modernise and staff it. Despite this progress there were still deficits in community resources, most notably the lack of a mental health centre and day hospital in Naas. The service, too, needed a specialised service for the elderly and for rehabilitation.

NORTHERN AREA HEALTH BOARD

Dublin North East served an ever-growing catchment. The mental health in-patient base was at the unsatisfactory St. Ita's Hospital, Portrane, which also catered for the St. Joseph's Intellectually Disabled Service. Both services were run by a common administration arrangement which served neither well, and was in addition, unfair to the personnel involved. As far as the mental health service was concerned, the admission wards were totally unsatisfactory and the need for the new acute admission unit at Beaumont Hospital was overwhelming. Why the planning and building of this unit had taken so long was difficult to understand. It will be recalled that the original unit, built almost 20 years ago, was taken over for the treatment of illicit drug usage. Non-hospital hostel accommodation for patients on the Portrane campus was far from satisfactory, and if not transferred to more appropriate community-based settings, should be modernised and improved. However, the Reilly's Hill complex had closed. Additionally, community-based resources were required for the service to supplement the recently established rehabilitation team; in addition a specialised service for the elderly was required.

The St. Joseph's Intellectually Disabled Service had improved in recent years in that much of the accommodation in St. Ita's Hospital had been upgraded and the new community-based residence at Clonmethan had been opened, taking patients from the hospital. However, there needed to be an increase in the number of community-based residences for this service. There also needed to be an increase in consultant staffing and much

improved integration with other, mostly voluntary services, providing inputs in the catchment area, which was, in effect, all of Dublin City and County, north of the Liffey. Specialisation was also required in service delivery to provide for target groups such as those with challenging behaviour and for the psychiatry of intellectual disability on a community responsive basis.

The Area 7 service for Dublin North East was deployed through a limited community service and two acute in-patient bases, at St. Vincent's Hospital, Fairview (which also provided longer-stay in-patient facilities) and at the Mater Hospital. This acute in-patient arrangement was unsatisfactory. St. Vincent's Hospital was a single specialty, stand-alone psychiatric hospital, and the Mater unit was too small and cramped for any meaningful service purpose. The obvious and rational requirement was for a larger unit in the Mater Hospital serving the entire catchment area, or more widely on a regional basis. Sadly, this was not provided for in the current extensive replacement and extension building plan for the hospital.

The Area 6 service embracing Dublin North West had been providing acute in-patient services for the Blanchardstown and Finglas sectors in completely inadequate premises in Unit 9 in James Connolly Memorial Hospital, Blanchardstown, which, at the time of inspection had been surrounded by mounds of builder's rubble to make matters even worse than they usually were. Later in the year, this unit had closed and patients had been transferred to Unit 2, as a temporary measure pending the completion of modifications to the new unit. At the end of the year, our information was that patients would transfer from unit 2 to the new unit in January 2004. This new unit, in addition to the general adult provision, had an acute assessment facility for the later life service, as well as another assessment sub-unit for early onset organic conditions and a new day hospital for these latter services.

The acute admission units for the Cabra and Finglas sectors remained in St. Brendan's Hospital in totally unsatisfactory conditions and both wards, male and female, were mainly occupied by long-stay patients with only very few available for acute patients. The plan was to admit patients from these two sectors to the new James Connolly unit in Blanchardstown but this was being held up by industrial relation negotiations. St. Brendan's Hospital itself was in poor condition with most of it being unfit for any form of care. The majority of patients were long-stay, including those in the homeless unit. Some improvements had been effected in the four special or intensive care wards. The Dublin Institute of Technology was in the process of buying the St. Brendan's site but the implications and time scaling of this was unclear and the uncertainty of this had not helped staff morale. Some of the community residences in this Area 6 service were in poor condition and required either extensive upgrading or replacement. A new sector headquarters and day hospital was about to open in Blanchardstown but further community development was required.

EAST COAST AREA HEALTH BOARD

This area was one of the Hanly pilot areas and the challenging implications for acute in-patient services have been referred to earlier.

The Area 2 catchment area covered Dublin South Central and had very limited community resources and the in-patient unit at Vergemount Hospital was totally unsuited to acute care. However, the new unit at St. Vincent's Hospital, Elm Park was ready and commissioned to receive patients by the end of 2003. Unfortunately, prolonged discussions involving administration and staff representatives had not concluded. In the meantime, the St. Camillus ward in St. Vincent's was operating at half its limited capacity and was not making any significant catchment contribution.

The Cluain Mhuire service for Dublin South East catered for a mainly middle class catchment with relatively few medical card holders. Given this, the allocation of 42 beds in the single specialty, stand alone St. John of God Hospital, Stillorgan, paid for by the East Coast Health Board seemed generous. The Cluain Mhuire (public) patients did not have access to the newly opened acute admission ward. The community base for the service was in Blackrock and served the entire catchment that functioned as one sector. The day hospital was in the Stillorgan Hospital. This was acknowledged to be unsatisfactory and an alternative site was being sought. The Burton Hall centre continued to provide high quality retraining and re-insertion programmes of an innovative nature. An early intervention, community-based, programme for psychosis for the entire board area had been proposed by this service, to be operated by this service and with in-patient requirements in Stillorgan. While in favour of such programmes, generally, the Inspectorate had reservations about this specific proposal for reasons stipulated in the detailed report on this service.

The Wicklow service (which excluded West Wicklow, catered for by the Kildare service) operated a limited community service and had acute in-patient accommodation in the single specialty stand alone Newcastle Hospital, which also sheltered elderly persons mostly transferred from St. Brendan's Hospital. However a new community residence was shortly to open in Arklow to supplement the day facility nearby. Towards the end of the year Newtown House in Newcastle had been acquired to serve as either a residential facility or as a sector headquarters and day hospital/centre for the mid sector. Surprisingly the service had suspended its liaison service to St. Colmcilles Hospital, Loughlinstown, leaving this to the Cluain Mhuire Service despite the majority of patients attending St. Colmcille's coming from the Wicklow catchment area. An additional sector team was required for this service as was a specialised team for the elderly.

The Central Mental Hospital was also administered by this Board.

THE MIDLAND HEALTH BOARD

This Board has responsibility for four counties, serviced by two services, Laois/Offaly and Longford/Westmeath. The issue arises whether, in line with a policy of regionalisation, these two services should not be unified, given that the new 50-bedded acute unit at

Portlaoise General Hospital will be over generous for its present catchment, and the unsatisfactory nature of acute facilities at St. Loman's Hospital, the stand-alone psychiatric hospital at Mullingar. The Laois/Offaly service had its new unit at Portlaoise General Hospital taken over on a temporary basis by general medical services and this was to be transferred to the psychiatric service in March 2004. It included an acute assessment sub-unit for the psychiatry of later life service, recently established. When occupied the current two admission wards in St. Fintan's Hospital would close and arrangements would be made to resettle the remainder of patients, mostly rehabilitation patients, in the community. As far as community services were concerned there needed to be residential, day and headquarter premises provided in the Birr sector.

The Longford/Westmeath service, despite some community developments in the under utilised Longford premises and in Mullingar, required a substantial presence on the soon-to-be developed site at St. Vincent's Hospital, Athlone. St. Loman's Hospital remained a stand-alone establishment unsuited for modern in-patient care. A considerable amount of capital had been spent on the upgrading of the admission unit, when a more appropriate response would have been to provide one in the general hospital or, more economically and more efficiently, use the Portlaoise unit for the combined service as suggested earlier. As matters stood, half of the unit was being used to accommodate elderly patients transferred from the three-storey St. Brigid's block while asbestos was being stripped from that building. When this has been accomplished on one floor these patients will be transferred back, to be followed by the transfer of the residents of the other two wards. Meanwhile the female admission unit had been transferred to the middle floor of the old hospital — a totally unsatisfactory arrangement. On a positive note, a specialised service for the elderly had been instituted but here again the negatives were substantial as this service had no acute assessment facilities and no day provision, other than makeshift accommodation located on the ground floor of the St. Brigids block.

THE MID-WESTERN HEALTH BOARD

In 2002 the Clare service closed and disposed of most of the former Our Lady's Hospital and campus and resettled patients in the community in a variety of different locations. Acute in-patient care was now being provided in the new acute unit in Ennis General Hospital which had a specialised sub-unit for acute assessment by the later life service. Long-stay patients had been accommodated in a Respond Housing complex in part of the campus that had been retained. These patients were now the subject of attention by the newly-established rehabilitation team. An upgraded building on another part of the retained land had now become the service headquarters. Additional community facilities were either obtained or shortly would be in Ennis and Ennistymon and the day premises at Shannon had been expanded.

At Limerick, just before the end of 2003, patients in unit 10 at St. Joseph's Hospital had been transferred to new nursing home type accommodation, Inis Guaile, at Parteen and the unit closed. Attempts were being made to transfer the remaining intellectually disabled patients to join their peers at the specialised facility at Lisnagry. Efforts were being pursued to advance the community placement of long-stay patients in St. Joseph's so that the hospital could eventually close. This was to be welcomed, as some of the remaining

accommodation in the hospital was substandard. The acute unit at Limerick Regional Hospital, despite some costly upgrading, was still unsatisfactory in that there were no suitable observation facilities for acutely ill patients. The use of the unit for children as young as 11 years with as many as three being present at any one time could not be condoned, not alone on general grounds, but for cost reasons as all were one-to-one nursed on a 24-hour basis. The specialised later life service still did not have a special assessment sub-unit in the acute unit and had other requirements as well which had not been met. In the community, major structural improvements were under way in the Roxborough Sector headquarters and day hospital in Limerick City. The newly provided premises at Kilmallock was functioning well.

The Board had taken on the provision of services for Tipperary North Riding and was currently staffing the community services of that service but in-patients had remained the responsibility of the South-Eastern Health Board at St. Luke's, Clonmel, and the policy was that the Mid West would establish a newly built unit at Nenagh Hospital for this 50,000 population catchment, The Inspectorate was opposed to this on the grounds that this size of catchment could not sustain a comprehensive, multi-specialty service. The better way to proceed was to spend the resources involved in providing a comprehensive community service with reliance for acute in-patient care on a handful of beds in the Limerick unit.

THE NORTH-EASTERN HEALTH BOARD

The Cavan/Monaghan service had completed its new building on the St. Davnet's Hospital avenue which had been progressed as a community residence but it had been suggested that it might function as a crisis unit on the closure of the admission unit at that hospital which now catered for only a handful of patients given that the acute admission unit at Cavan General Hospital was capable of catering for both counties. Meanwhile the acute community-based rapid response, rehabilitation and home care services were operating well and giving a lead in service delivery in this country. There was a requirement for more community-based physical resources to decentralise some of the functions based on the St. Davnet's campus.

In County Louth, there had been remodelling of the admission unit at St. Brigid's Hospital, Ardee and the numbers of long-stay patients had been reduced with the transfer of intellectually disabled patients to alternative accommodation. The plan to provide acute in-patient facilities at the Louth Hospital, Dundalk were proceeding, but because the day care and sector premises at the hospital were rather cramped the search was on for more spacious accommodation. The newly-opened residential unit in that town was operating satisfactorily.

The Meath service was still not administratively independent of the Louth service and was poorly resourced in community terms. However, attempts were being made to source community accommodation in Kells but this was proving difficult and the Dunshaughlin day premises was, apparently, to be enlarged. The acute unit at Navan was working well but did require the back up of enhanced community resources and some designated

accommodation for the new later life service. Finally, the relationship between the Meath and Louth services and those of Cavan/ Monaghan should be considered from the point of view of regionalisation.

THE NORTH-WESTERN HEALTH BOARD

At Sligo, the service had remained static and not much progress was to be reported. Unfortunately the building of the new acute unit at the General Hospital had not advanced, despite having been “signed off” as long ago as 1994 by all parties. However, the local service providers had felt that the agreed brief needed additions, to which the Inspectorate did not subscribe, and so the matter had not progressed. The Board had commissioned the Sainsbury Trust, a group from the United Kingdom to advise it on its psychiatric services of the future, without any reference to the Inspectorate. However, in the light of the Hanly recommendations on regionalisation, consideration should be given to rethinking the delivery of services in the region.

In Donegal, some additional residential accommodation had been acquired in Letterkenny to accommodate patients from the three remaining wards in St. Conal’s Hospital thus moving the hospital towards closure. However, the acute unit at the General Hospital, Letterkenny needed upgrading or replacement, the former being the more realistic option, cost- wise. This could be done on a piecemeal basis by reducing the number of beds by half, at least temporarily, while the work went on; total evacuation would mean the transfer of the admission facility back to St. Conal’s Hospital, obviously an unsatisfactory solution. A new community residence had been acquired in Dungloe to replace the existing one, which had become unsatisfactory.

THE SOUTH-EASTERN HEALTH BOARD

The most significant event in this Board’s mental health activities during the year had been in the Carlow/Kilkenny service where the new psychiatric unit at St. Luke’s Hospital, Kilkenny opened during the year. As a result, the admission wards at St. Dymphna’s Hospital, Carlow and St. Canice’s Hospital, Kilkenny had closed. At the same time further initiatives saw the opening of a new support residence at Greenbanks, Carlow town and the conversion of the residual accommodation in St. Canice’s to a care of the elderly facility in association with the generic services for this age group. On St. Canice’s campus there were plans to build three bungalow type residences on an integrated plan to cater for the intellectually disabled persons currently residing in Kelvingrove. Community mental health centres and day hospitals, however, were an urgent requirement in both Carlow and Kilkenny towns. A specialised service for the elderly had been instituted with acute assessment facilities in the new unit at Kilkenny. However, the team needed strengthening on the personnel side and the absence of day hospital accommodation for this service was a drawback.

There were many problems in the Tipperary service. Apart from the facilities in Tipperary town, there was little available by way of community development in the South Riding area. Conditions in St. Michael’s admission unit at Clonmel were generally poor from most points of view and the unit required either extensive upgrading or replacement.

Conditions at St. Luke's Hospital, Clonmel, with its three wards opened in the 1980s, were very unsatisfactory with intellectually disabled residents deprived of appropriate specialised inputs and sharing their accommodation with non- intellectually disabled, functionally ill patients. To compound matters, newly-admitted mentally ill patients were sometimes sent directly or transferred to these wards either for management purposes or because there were no beds available in the St. Michael's Unit. This latter contingency arose because of lack of a comprehensive admission policy or adherence to it. Elsewhere in St. Luke's care provided was mainly for persons who had grown old in the service having been admitted many years ago. Unfortunately the initiatives at Cashel, which would have provided both residential and day facilities for the mental health service, had not become operational during 2003.

The Wexford service, too, had many problems. Community services were inadequate and apart from a limited day provision at Wexford town, a restricted day facility at Enniscorthy for the newly established service for the elderly and some community residential accommodation, the deficits were substantial. The lack of day services meant that many patients still travelled from as far away as Wexford town to St. Senan's Hospital for day care. But the most serious defect in the service, and the one most urgently in need of rectification, was the lack of any acceptable acute admission facility. The existing arrangement, with the female unit effectively in one room in the old hospital, was quite unacceptable from any point of view and the male arrangements were little better. The sooner a new acute unit was made available at Wexford General Hospital or elsewhere on a regional basis, the better. A further matter for concern was the number of intellectually disabled persons in the hospital who required alternative and more appropriate placement, which did not appear to be in sight.

THE SOUTHERN HEALTH BOARD

This Board provided services for the counties of Kerry and Cork through five catchment services and a combined special care and rehabilitation unit in Cork city.

In Kerry, a new day hospital opened during the year at Caherina in Tralee to add to the purpose-built community residence in Listowel, which became operative in 2002. Plans had been drawn up to provide a close observation area in the acute unit at Tralee General Hospital since that hospital had been designated a district mental hospital for the reception of PUM patients to end such admissions to St. Finan's Hospital, Killarney. In addition, the plans provided for an occupational therapy department. In Killarney there were plans to resettle some of the longer stay hospital patients at St. Finan's in some new premises shortly to be built nearby. This was welcome as some of the wards still open in this hospital were unfit for patient care. A plan for the ultimate sale of the hospital was at an advanced stage.

In West Cork, a new community residence was about to open just behind the General Hospital in Bantry and plans were afoot to convert other premises nearby to day hospital usage and to redistribute patients in community residences more appropriately. The acute unit in Bantry Hospital had been designated as a district mental hospital last year in an

attempt to halt the admission of patients on PUM forms to Cork City facilities. In recognition that there was no capacity under existing conditions for close observation, the Inspectorate had requested in 2002 that the service draw up plans for such a facility but this had not been done. As a result, patients from the catchment were still being brought to Cork. All in all, the Inspectorate was of the view that this West Cork catchment was too small in population size to maintain a comprehensive self-sustaining service of multi-specialty nature and, in particular an independent acute unit, and that the small number of patients requiring acute admission should be better catered for in Cork, which, in effect, was what was largely happening in any case. It would have been better to operate a crisis service from Bantry and make better use of sparse nursing resources through community deployment. There had been, in addition, substantial nurse shortages with many posts unfilled and attempts to fill vacancies with other grades of personnel had been, predictably, resisted by nursing unions.

The South Lee service had suffered from years of non-development with virtually no community services. Only recently had it sectorised in an attempt to rationalise its function. In addition, the acute unit at Cork University Hospital was quite unsatisfactory in design and scope, providing no suitable acute observation areas and no sub-unit for the newly established specialised service for the elderly. In addition, day space for patients and their activities were quite inadequate. The designated facility, St. Catherine's at St. Finbarr's Hospital, which admitted patients directly, should be de-designated and its usage critically scrutinised. In common with all Cork services there was no specialised rehabilitation service. Additionally, at the least, a part-time liaison service was required.

The North Lee service was the best resourced service in Cork aided by the new acute unit at the Mercy Hospital. There had been additions to the community aspects of the service recently, notably at Macroom and Middleton. However, the Middleton residential facility at Owenacurra should be de-designated. A specialised elderly and liaison service were required.

By contrast, matters were less than satisfactory in the North Cork service. There was little by way of community facilities, although a new community, purpose-built residence had opened in Mallow some three years ago and a further residence was planned in the same town together with a new day premises in Kanturk. These, together with the development envisaged for Fermoy would significantly add to the quality of care provided by this service. However, the key element in moving this service forward was the provision of an acute unit at Mallow Hospital — a matter that was not being confronted with any degree of urgency. As matters stood there were two admission units at St. Stephen's Hospital, Glanmire, both old sanatorium units and neither suitable for its purpose. In any case, pending the proposed Mallow initiative (or some other general hospital-based arrangement in the light of Hanly regionalisation) there was no reason why one should not suffice and the Inspectorate advised the closure of one of these two admission units in the interim. Meantime, there was a substantial number of patients in St. Stephen's Hospital, most of whom had been transferred there on the closure of Our Lady's. There was an obvious need for their rehabilitation and resettlement and the subsequent closure of St. Stephen's Hospital.

The former St. Anne's unit at Shanakiel had been upgraded to take the last remaining patients from St. Kevin's ward in Our Lady's Hospital and was now referred to as Carraig Mór. Legally it was still part of Our Lady's and it was on this basis that it was able to receive and detain involuntary patients. Unfortunately, the requirements of the Mental Treatment Act, 1945 were mostly not adhered to in transferring patients to it, as often happened when no beds were available in the Cork admission units or when patients were perceived as too difficult to manage in these units. There were two floors to the building, one containing the former long-stay patients from St. Kevin's, most in need of rehabilitation and on the second floor, patients who needed the services of a team specialised in intensive care treatments, neither of which were available. Instead, the Cork Clinical Directors in rotation carried out the administrative medical functions of managing the unit and a quite different arrangement, as far as teams were concerned, was in place for day-to-day clinical management. Both arrangements were unsatisfactory and the rationale behind them was baffling, although there may have been other considerations of a more obscure nature operating. At any rate, matters were seriously in need of adjustment in the interests of patient care. Externally the building was surrounded by a rather frightening array of high palings, emphasising the security aspects of the premises, but surely unsettling for a first time patient to the service sent here because there were no beds available in the admission unit or for other reasons.

The Western Health Board

This board had responsibility for four services, West Galway, East Galway, Roscommon and Mayo.

West Galway was catered for by limited community provision and with acute in-patient facilities in a psychiatric unit in Galway University Hospital and with continuing care/rehabilitation facilities in Merlin Park Hospital, Galway. New community-based premises and developments were being planned for Clifden together with increased residential accommodation in Galway City. These would enable some of the patients hospitalised in Unit 9 in Merlin Park to move out of that setting to community living and would complement a recently opened high-quality house in a nearby housing estate. This additional residential provision was needed, as most, if not all, of those in Unit 9 were ready for community placement. In the meantime, the Unit should be dedesignated and the practice of transferring patients from the Acute Unit, to make a vacancy, should be discontinued. Plans to upgrade the Unit in University College Hospital, Galway and, particularly to create a high-observation unit within it, had not materialised but were urgently needed, if only to reduce the transfer of patients from this catchment to St. Brigid's Hospital, Ballinasloe. Efforts were being made to source a site or premises for a day facility in the city so as to replace Halla Pádraig, which was quite unsatisfactory.

In East Galway the predominating issue was the state of St. Brigid's Hospital much of which had been severely criticised by the Inspectorate in 2002 together with those management mechanisms which impeded progress. As a result a "reshaping" group had been established to move matters forward. This process was moving at a very slow pace but some progress had been reported and one unsatisfactory ward had closed. The admission wards had been refurbished but structurally were not designed for modern acute in-patient

psychiatric practice. Nothing further had come of the plan to provide such care at Portiuncula Hospital, Ballinasloe. A specialised service for rehabilitation was now in place and such a specialised service for the elderly was shortly to begin operation.

There had been little change in Roscommon where minor adjustments had been made to the acute unit in Roscommon Hospital to accommodate disturbed patients. Premises had been acquired in Roscommon town to provide day facilities and additional residential accommodation although this later was encountering some planning permission difficulties. The service was seeking new day premises in the Athlone sector. The small population (50,000) of this catchment compromised its capacity to provide comprehensive, multi-specialty services. It and the other services in the area needed to be scrutinised in the light of the Hanly proposals on regionalising acute hospital services. In Mayo, the most exciting event of the year had been the opening late in the year of the new acute unit in Castlebar General Hospital, almost simultaneously with the new residential and workshop premises in Castlebar and the closure and immediate remodelling of the St. Teresa's unit which, when completed, would serve as a rehabilitation unit and lead to the absorption and reskilling of some long-stay patients in St. Mary's; at this point the old hospital would be approaching closure. In the community a new sector headquarters and day facility was nearing completion in Claremorris.

PRIVATE, PRIVATE CHARITABLE AND AUTHORISED INSTITUTIONS

These were referred to as the private hospitals. They comprised two large acute hospitals and a number of smaller hospitals catering for in the main elderly persons all based in Dublin. Collectively they provided about 500 beds. All have been considered in the main body of this report individually. St. Patrick's and St. John of God, Hospitals drew their patient clientele from the entire country, both were stand alone, single specialty in-patient establishments of high quality and did not provide community services although St. Patrick's was negotiating a day hospital initiative with private medical health insurers. Both had been the subject of remodelling and upgrading recently. Some of the smaller hospitals were operating in somewhat cramped premises but Bloomfield was moving to a new location and building a replacement hospital while the Kylemore Clinic was seeking to extend.

CHAPTER TWO

EASTERN REGIONAL HEALTH AUTHORITY

EAST COAST AREA HEALTH BOARD

CLUAIN MHUIRE MENTAL HEALTH SERVICE, (AREA 1)

2003 INSPECTION

INSPECTED ON 10 DECEMBER 2003

GENERAL DESCRIPTION OF THE SERVICE

The total population of this catchment area was 172,000 and it was not sectorised. The Area 1 and part of Area 2 service which was operated by the Hospitaller Order of St. John of God under a service agreement with the Eastern Regional Health Authority had its headquarters at the Cluain Mhuire centre and operated general adult services through a network of community-based services. In addition, it shared a specialised service for the psychiatry of later life with the Area 2 service. Rehabilitation services were based at Burton Hall. Liaison/consultation services were supplied by a specialised team to St. Michael's Hospital, Dún Laoghaire and to Loughlinstown Hospital. A pilot service for the homeless mentally ill of the area had commenced in August 2003.

IN-PATIENT CARE

In-patient care was provided at the single specialty, stand alone St. John of God Hospital, Stillorgan, which had forty-two beds (contracted as public beds) in five integrated wards. This Report of the Cluain Mhuire service should be read in conjunction with the reports on that hospital.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	2	9	8	—	—	19	73.1
3-12 Months	—	—	2	2	—	—	4	15.4
1-5 Years	—	1	—	2	—	—	3	11.5
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	3	11	12	—	—	26	100
% of Total	—	11.5	42.3	46.2	—	—	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
2	9	-	1	6	-
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
2	3	-	-	3	26

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	20	17	37
Temporary	6	6	12
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	26	23	49

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
386	2.2	N.A.	N.A.	86.0	14.0	394	4

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	35	52
Day Centres	1	68	118
Out-patient clinics	1	N.A.	2,262

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
3	15	1	15	1	20

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
16	17.5	38	16.23	9.86

COST

The cost of the Cluain Mhuire Service was €9.4 million in 2002.

GENERAL COMMENTS

Together with the new St. Vincent's, Elm Park psychiatric unit (Area 2) and Newcastle Hospital, Wicklow, the 42 public beds of St. John of God Hospital, Stillorgan provided in-patient care for the East Coast Area Health Board catchment area with a population of 350,000. This was one of the pilot areas of the Hanly Report which recommended the regionalisation of acute hospitals, multi-specialist services in regional hospitals, including psychiatry which, in this case, had to be St. Vincent's Hospital with subsidiary roles for other, smaller hospitals. The logical progression of this line of thought would have consequences for the role and function of the other two current acute services in the board's area and questions the need for 130 acute beds as at present. Such a change in service function might result in a substantial deployment of current in-patient staff to community services.

This service was centralised in its community dimension in the Cluain Mhuire centre at Newtown Park Avenue, Blackrock and had 42 in-patient beds in the St. John of God Hospital, Stillorgan which was generous for the population served. The community residential facilities were of a high standard, as was the quality of the in-patient accommodation. However, the Inspectorate noted that public patients did not have access to the newest ward in the hospital. Both the location and physical characteristics of the day hospital on the campus of St. John of God Hospital were inconvenient and the service was seeking a more suitable alternative. One consequence was that the day service did not cater for seriously ill psychotic patients although a group was examining ways in which this deficit might be remedied.

A number of interesting initiatives had been commenced in this service. These included an approach to the problem of the homeless mentally ill and alcohol problems in the Area jointly with the local authority in Dún Laoghaire and Rathdown; a small staff input to this project had been dedicated but additional funding was required to make the endeavour comprehensive. An early intervention programme in psychosis had been proposed — an initiative which the Inspectorate was happy to support in general terms. It was proposed that all such patients from the three services of the Board, if needing in-patient care, would be hospitalised in St. John of God Hospital, Stillorgan. The Inspectorate wondered if this project could not be operated on a co-operative basis with each of the three services, augmented by the research team, caring for its own patients but using the common methodology. This would have the advantage of each having the experience, important for training purposes, of caring for newly psychotic patients, an essential ingredient of any services clinical experience. Additionally, it would not compromise continuity of care from acute to later stages of illness. However, the project in its present form had not been funded because of the substantial cost involved. Modification along the line suggested might reduce cost and increase the likelihood of funding.

In terms of multi-displinary this service was relatively well staffed. There was a specialised service for later-life psychiatry which was shared with Area 2; it had acute assessment

facilities at Stillorgan and continuing care accommodation elsewhere. A liaison/consultation service was provided to both St. Michael's Hospital, Dún Laoghaire and to St. Colmcille's Hospital, Loughlinstown, where the majority of the patients came from Co. Wicklow. There was an extensive and impressive rehabilitation service centred on the Burton Hall premises. However, it had not been seen appropriate to follow usual practice and establish a consultant-led specialist team exclusively for rehabilitation. It was hoped that the in-patient adolescent service in Stillorgan, which had closed a few years ago, would reopen in 2004. A "dual diagnosis" day facility had been established at Cran-nóg and the day centre, Corres Centre, which catered for 30-50 patients daily formerly at Burton Hall, had now moved to the new Enterprise Centre nearby. The new low-support community residence at Leopardstown Avenue was now operational.

During 2002, 54 patients, 34 male and 20 female were admitted from the public service as temporary patients to St. John of God Hospital; five public patients had their temporary admission orders extended and 14 patients admitted as voluntary patients were re-graded to involuntary status during the course of their hospitalisation. Also in 2002, one public patient was transferred under Section 208 of the Mental Treatment Act, 1945 to the Central Mental Hospital. Twelve public patients took their own discharge from the hospital during 2002 and arrangements were in place for follow up where appropriate. Three public patients became new long-stay as they had more than one year's continuous hospitalisation.

In 2002, there were 287 consultations by the consultant psychiatrist at St. Colmcille's Hospital and a further 60 at St. Michael's Hospital, Dún Laoghaire, resulting in 16 patients being admitted to in-patient care. In addition, a further 187 patients at St. Colmcille's Hospital and 20 at St. Michael's Hospital, Dún Laoghaire were assessed by the liaison nurse, resulting in eight patients from St. Colmcille's Hospital being admitted to in-patient care. Statistical data relating to other referrals to out-patient department, day hospitals, etc. was not available at the time of our inspection.

There were seven complaints and 12 requests for information under the Freedom of Information Act, 1997 made to the local complaints appeals manager during 2002. A document entitled "*Resolution of Client Concerns*" which indicated best practice for dealing with complaints had been introduced in this service early in 2002. The service also had a draft version of a patient's charter which was under discussion at the time of this visit.

In 2002, there were 109 episodes of seclusion involving 23 public patients at St. John of God Hospital. Eleven patients from the catchment area were prescribed ECT. There were 447 accidents to patients and 10 accidents to staff during 2002; none were deemed serious. There were 55 assaults on patients by other patients and 75 recorded assaults on staff; again, none were deemed serious.

There was one high-support, one medium-support and three low-support community residences administered by this service accommodating 50 residents at the end of 2002. There were 13 admissions and 16 discharges during 2002. Sixteen staff were employed in the community residences in addition to 18 volunteers who made a valuable contribution to

all programmes offered by the Cluain Mhuire services. Research at the Cluain Mhuire service involved a collaborative effort from all clinical and administrative teams. This centre had been approved as one of a few European research centres for schizophrenia and bi-polar affective disorders by the Stanley Foundation (USA). Research work continued into a number of studies in collaboration with the Department of Clinical Pharmacology, Royal College of Surgeons, Health Research Board, Mater Hospital, Trinity College and the Coombe Women’s Hospital.

RECOMMENDATIONS

The Inspectorate had no specific recommendations to make at this time, other than that the service providers would consider the comments made throughout the report.

**PSYCHIATRIC UNIT, VERGEMOUNT CLINIC, (AREA 2) — 2003 INSPECTION
INSPECTED ON 22 OCTOBER 2003**

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 99,577 was divided into three sectors as follows:

Sector	Population
Sector 1	30,089
Sector 2	40,355
Sector 3	29,133

In-patient care was provided at Vergemount Clinic. In addition, there were two de-designated elderly care units on the campus of Clonskeagh Hospital administered and staffed by the mental health services. The general adult service had limited community facilities — a day centre at Glenmalure, Milltown, and a number of community residences within the catchment area.

The Area 2 services provided a general adult service and a service for later-life psychiatry which was shared with Area 1 with premises on the St. Vincent’s Hospital campus and at Tivoli Road, Dún Laoghaire. Additionally, general adult consultant psychiatrists, on a part-time basis, provided for an addiction service at Baggot Street Hospital and a perinatal psychiatry service at the National Maternity Hospital, Holles Street.

IN-PATIENT CARE

In-patient care was provided with 29 beds in Vergemount Clinic in one male and one female unit.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	10	7	3	—	20	91.0
3-12 Months	—	—	—	—	—	—	—	—
1-5 Years	—	—	—	2	—	—	2	9.0
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	—	10	9	3	—	22	100
% of Total	—	—	45.5	40.9	13.6	—	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	10	—	5	3	1
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
—	2	—	—	1	22

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	14	10	24
Temporary	3	2	5
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	17	12	29

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
333	3.3	68	20.4	89.5	10.5	332	—

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	45	1,249
Day Centres	1	32	45
Out-patient clinics	2	336*	965

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
1	7	1	14	1	14

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
14	9.5	116	54	11

COST

The cost of the Vergemount Clinic Service was €11.6 million in 2002.

GENERAL COMMENTS

The Area 2 service was generally unsatisfactory and inadequate. The acute unit at Vergemount was totally unsuitable for patient care and, more worryingly, was unsafe because of the lack of observation facilities. The new unit at St. Vincent's Hospital, Elm Park, which would replace the Vergemount Clinic was now completed and ready for occupation. The Inspectorate understood that some pre-commissioning and equipping works were still to be carried out. However, the negotiations with unions and others which delayed the opening of new acute general hospital units throughout the country had not concluded.

There was a serious deficiency of community services: no acute day hospital, no sector headquarters or mental health centres and limited community residential accommodation. It was proposed that the vacated acute unit at Vergemount might be requisitioned for some of these functions when acute services relocated to St. Vincent's Hospital. The Inspectorate felt this was a sensible proposal. The Inspectorate welcomed the imminent opening of the new high-support residence, Morehampton Lodge, taking eight patients initially and eventually rising to 14. This opening had been delayed for the past year because of fire and safety requirements. It would require nine nurses to staff it and the Inspectorate was informed that these would be sourced without difficulty. Of the 116 nurses available to the service, 52 were employed mainly with the care of the elderly in Whitethorn, La Brun house, Clonskeagh and at Cois Ceim, Tivoli Road, Dún Laoghaire with the remainder only available for the general adult service and of these only six were deployed in community outreach activities. There were 16 younger patients in one of the

units for elderly persons who had no access to rehabilitation facilities. It was noted that the later-life service was shared with Area 1 and the Inspectorate felt that each area should have its own service as there were two consultants in place.

In 2002, there were 35 involuntary admissions to the Vergemount Unit with no extensions of involuntary admission forms. Two patients admitted as involuntary patients were re-graded to voluntary status; seven patients admitted as voluntary patients were re-graded to involuntary status in the course of their hospital stay. There were no deaths in this service in 2002. Nine patients took their own discharge from the unit against medical advice in 2002 and follow-up procedures were in place, if deemed appropriate. During the year, 14 patients were transferred from this unit to St. Brendan's Hospital and a further 14 to St. John of God Hospital. The beds in St. John of God Hospital were paid for by the East Coast Area Health Board as no alternative service facilities were available to Vergemount Clinic.

In 2002, 53 patients were placed on one-nurse to one-patient special nursing supervision and there were 538 spans of special supervision, a marked increase from 36 patients and 388 spans in 2001. Special nursing was initiated and discontinued on the instructions of the patient's consultant psychiatrist and primarily occurred because of assessed significant risk of self-harm or harm to others. The high level of special nursing in this service can be accounted for by the poor design and layout of the existing Vergemount Unit. The high-observation area in the new unit at St. Vincent's Hospital, Elm Park where the patients would re-locate would not eliminate the need for special nursing supervision: it would however, offer the potential to reduce its use considerably, by providing increased choice and more flexibility to the professional staff when tailoring care plans to suit individual patient needs. All risk issues relating to special nursing should be reviewed by the policy review committee and specific auditable criteria for levels of observation introduced.

During 2002, 14 patients were prescribed ECT at the Vergemount Unit: all arrangements were satisfactory. Valid consent was obtained in all cases and an information booklet based on the Royal College of Psychiatrists' guidelines and the Mental Treatment Act, 1945 was available for patients and patients' families. This booklet, which included information about the risks of ECT and availability of alternative treatments, enabled individuals and their carers to make an informed decision regarding the appropriateness of ECT for their circumstances.

Statistical information relating to accidents and incidents at the Vergemount unit was not available for the year 2002. The policy for the recording of accidents and incidents should be extended to include regular scrutiny of all accidents, incidents and assaults which would provide an analysis by time of day/night, geographical location, cause of accident and incident and nature and degree of injury.

There were no research projects governed by the Clinical Trials Act 1987-1990 undertaken in this service. There was one complaint and six requests under the Freedom of Information Act, 1997, made to the local complaints appeals manager during 2002: all appeared to be dealt with satisfactorily.

Out-patient clinics were held at two locations, Baggot Street and Irishtown. An appointment system was in operation and one sector had a small waiting list which was prioritised by the consultant psychiatrist. There was a need to develop a system whereby out-patient appointments were confirmed by secretarial staff with appropriate follow-up of non-attendees. The facilities at Baggot Street were not satisfactory: conditions were cramped; the rooms were too small with inadequate sound proofing, presenting problems relating to patient confidentiality. The facilities at the Irishtown health clinic were reasonably satisfactory. A feature of this service was the number of immigrants and non-nationals presenting at out-patient clinics. This was proving time consuming for staff due to language barriers and there were difficulties relating to follow-up of some of these patients.

A safety statement for the unit was dated 1994 and required review and updating. There was no record of any local safety audit. Copies of the Eastern Regional Health Authority Shared Services safe work practice standards were available at each location for staff information and reference. The safety committee should produce site-specific safety statements for each area detailing responsibility to local managers for carrying out their own risk assessments in the workplace. A number of policies, procedures and guidelines had been reviewed. However, these would require further review and updating in the context of the re-location of acute services to St. Vincent's Hospital, Elm Park.

The Inspectorate welcomed the introduction of the information guide for patients and their families, the visitors guide and the patient satisfaction evaluation form. Comments received from patients in the patient satisfaction form should be included in an annual report produced by the local management team.

Comprehensive medical notes were recorded for each newly-admitted patient. Medical records had an open pocket on the inside rear cover containing copious amounts of clinical material. Risks associated with loose material in a clinical file included delays in accessing pertinent information and lost or misfiled information. Written instructions and filing of documentation within the medical record was required. The patient's name should be clearly recorded on each continuation page and all entries should be signed in full. Time of input should also be recorded as this was useful in determining any delays in assessment or treatment.

As mentioned in previous reports, there was a high turnover of nursing personnel in this service. However, recruitment from overseas had helped alleviate the acute staffing difficulties experienced in previous years. Revised nursing documentation had been introduced using the 'Oram' model of nursing which replaced the 'Roper' model previously in use. The patient assessment form was comprehensive and completed satisfactorily. The admission, assessment and individual care plans were well documented. Care plans were reviewed weekly and more often if necessary and a team nursing system was in operation. Nursing records contained relevant information relating to the nursing observation of patients; all were accurately dated and timed using the 24-hour clock. A comprehensive manual was available as a reference tool to aid nursing assessment and offered guidelines on nursing interventions. In addition to setting standards of record keeping this was a comprehensive psychiatric nursing manual which facilitated the easier changeover to the

new model of nursing. Ideally, the patients themselves should be more involved in making choices and decisions about their own care and treatment and this should be clearly recorded in the nursing documentation.

There was a written policy on medical preparations and the standard of prescription writing in this service was reasonably satisfactory. All prescriptions were signed and dated individually and discontinuation columns had one date and one signature for each drug discontinued. The drug administration recording card had provision for the nurses signature in full; there was also provision for recording drug allergy and drug sensitivity so that the information was rapidly available to staff. This section was completed in all cards examined.

RECOMMENDATIONS

It is recommended that:

1. Negotiations proceed to open the new psychiatric unit at St. Vincent's Hospital, Elm Park, as soon as possible;
2. When vacated, the unit at Vergemount Clinic be retained by the Mental Health Services and adapted to serve as a sector headquarters/community mental health centre and acute day hospital as an initial step in addressing the deficits in this service.
3. A specialised rehabilitation team be put in place to meet the needs of the service;
4. A liaison team to service the accident and emergency department and wards of St. Vincent's Hospital, be recruited.

CENTRAL MENTAL HOSPITAL — FIRST 2003 INSPECTION

INSPECTED ON 4 JUNE 2003

GENERAL DESCRIPTION OF THE SERVICE

The Central Mental Hospital (CMH) provided a forensic psychiatric service and secure psychiatric care for the entire country — a population of approximately 4 million.

IN-PATIENT CARE

In-patient care was provided at the 89-bedded Central Mental Hospital, Dundrum, Co. Dublin.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	8	3	—	—	11	14.9
3-12 Months	—	1	3	—	—	—	4	5.4
1-5 Years	—	1	25	1	—	—	27	36.5
> 5 Years	—	—	7	20	4	1	32	43.2
All Lengths of Stay	—	2	43	24	4	1	74	100
% of Total		2.7	58.1	32.4	5.4	1.4	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
2	53	1	4	1	—
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
7	—	—	4	2	74

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Guilty but Insane	20	—	20
Unfit to plead	4	1	5
Remand/Sentenced/ transferred from prison	29	—	29
Section 207	7	—	7
Section 208	7	2	9
Total	67	3	70

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate	No.	% of all	Voluntary	non-voluntary		
105	—	—	—	—	100%	118	2

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
16	13	49	22.5	2

COST

The cost of the Central Mental Hospital service was €12m in 2002.

GENERAL COMMENTS

The Central Mental Hospital was established under the provisions of the Central Criminal Lunatic Asylum (Ireland) Act 1845 and was the only forensic hospital in Ireland. The hospital provided mental health care in medium- and high-security conditions. Patients were admitted to the hospital under two broad categories, from the criminal justice system or under the provisions of the Mental Treatment Act, 1945 and amending legislation. Patients admitted under the Mental Treatment Act, 1945 were admitted under Section 208 of that Act. Section 207 of the Mental Treatment Act, 1945 was no longer used for admission purposes. However, there were seven patients detained in the hospital under this section of the Act on the date of Inspection.

The issue of a person's mental condition in criminal proceedings arose in two ways, as a preliminary matter relating to a person's fitness to be tried, and secondly, as a defence to a criminal charge. Issues relating to the competence or capacity of an accused person to be tried were dealt with under the existing law, the Lunacy Ireland Act, 1821 and the Juries Act, 1976. If a person was found unfit to be tried by a Court he/she must be detained in the Central Mental Hospital. There were five patients detained under this section on the day of the Inspectorate's visit.

Twenty-nine patients in the hospital on the day of inspection were transfers from the prison system, having been detained on remand or serving a sentence. Patients were transferred on either a hospital order or a ministerial order signed by the Minister for Justice, Equality and Law Reform.

In addition to in-patient care, this forensic psychiatric service provided (on request) psychiatric forensic assessment for all of the health boards in the country. It also provided the Irish prison population with an assessment and an "in reach" treatment service to all of the prisons in the greater Dublin region. Out-patient clinics were established in the last three years in Cloverhill, Wheatfield, Mountjoy, Arbour Hill, and the Dochas centre. This had a positive impact on the number of admissions.

Following recommendations by the Central Mental Hospital Review Group a project team was established to examine the redevelopment of the old building. This project team met on a monthly basis with a view to producing a report on the refurbishment of the hospital. This would involve major changes, such as adapting all of the existing accommodation to en-suite purposes, the establishment of enhanced day facilities as well as hostel accommodation on the campus and the restructuring of the perimeter wall to allow some accommodation be outside the present security fence. The capital cost of all this refurbishment was estimated at between €30m and €40m and it was hoped that this project team would report to the Eastern Regional Health Authority shortly.

While the overall physical conditions offered to patients in the more modern units at the hospital were satisfactory, conditions in the old building were not. As mentioned in previous reports the Inspectorate was concerned that because of the national economic situation some of the necessary development work here would be put on hold. Modernisation

was required to ensure that living conditions were conducive to the treatment and welfare of patients.

The main building and the in-patient facilities in Units 1, 4 and 5 were unsatisfactory and needed to be substantially upgraded if they were to be retained for their present purpose. The seclusion accommodation in Unit 1 and in Unit 4 was unfit for a mental health institution of the 21st century. These conditions needed to be attended to as a matter of urgency. The Inspectorate accepted that some redecoration in Unit 1 had improved matters somewhat.

The Inspectorate welcomed the closure of Unit 5 and the relocation of patients from there to the upgraded facilities at Unit 2. It was noted that Unit A had closed and there were plans to relocate female patients from Unit 4 to this facility in the weeks after this inspection. The closure of Unit 4 would release one section of the hospital and this would facilitate redevelopment work to modernise the in-patient residential accommodation.

All patients in the old building of the hospital were locked into rooms at night and had to slop out in the mornings, as there was no in-room sanitation. Concerted management action was required to ensure that patients were relocated from these facilities as a matter of urgency. Unit A offered a better standard of accommodation than the old building and it was hoped that the female patients would be accommodated there. The new Units had low ceilings and appeared crowded. However, the inspectorate welcomed the easier access to courtyards for patients residing in these Units. The courtyards could be better maintained, with the addition of garden seating and shrubbery.

The courtyard in the main building, used exclusively by patients in Units 1 and 2, was in a disgraceful condition. Guttering was missing from parts of the building; external doors had not been painted, garden furniture was broken, the grass was covered with litter and the general appearance was unkempt. Greater efforts should be made to maintain this area in an acceptable manner.

The Inspectorate noted the improved decorative state of Units 1, 2 and 7. The relaxed atmosphere of the low secure ward of Unit 7 was noted. The Inspectorate spoke to a number of long-stay patients and they were all happy and comfortable in their surroundings. The Inspectorate welcomed the therapeutic and homely atmosphere in the residence situated on the grounds of the hospital, known as the Hostel. The redecoration and refurbishment of the ground floor was welcomed. Similar refurbishment was required on the first floor which was overcrowded.

At the time of inspection nine patients were hospitalised under Section 208 of the Mental Treatment Act, 1945; one from the Southern Health Board and the remainder from the Eastern Regional Health Authority area. Guidelines on the transfer of patients under Section 208 as published in the annual Reports of the Inspector of Mental Hospitals were followed. The seven patients detained under Section 207 of the Mental Treatment Act, 1945 were all long-stay patients of the Central Mental Hospital. Efforts should be made to rehabilitate these patients and return them to their referring service.

Discussions were underway between the East Coast Area Health Board, the Department of Health and Children and the Department of Justice, Equality and Law Reform with a view to developing a service level agreement to facilitate a more rapid transfer of patients from the prison system to the hospital for intensive treatment and discharge back to the prison system. It was estimated that the transfers would increase from the present 100 admissions to 300. This would require an additional thirty beds and it was hoped to use the vacant beds currently in the hospital for this purpose. It was estimated that 60 staff would be required to service these beds at a recurring cost of €6m revenue phased in over two years. These matters were under discussion at the time of the visit but no agreement had been reached.

There were 1,248 psychiatric assessments at Cloverhill prison and a further 1,768 reviews in 2002. Figures for Wheatfield, Dochas centre, Mountjoy and Arbour Hill prisons were not available at the time of the visit of the Inspectorate. This service provided 300 court reports at Cloverhill, 10 at Arbour Hill and 50 at the Usher's Island complex. The Usher's Island complex was the only community out-patient clinic and day facility providing a sheltered workshop at the city centre. The out-patient clinic saw approximately 100 new referrals and a similar number of follow-up patients each year. The sheltered workshop provided 6 places for young offenders on a five-day week basis working in conjunction with Fás and the probation and welfare service.

There were 105 admissions to the hospital in 2002: 43% of patients had been hospitalised continuously for 5 years or over and a further 36% hospitalised continuously for 1 year or over. The bed complement of the hospital was 89 but due to staff shortage the hospital was operating on 75 beds.

Prior to this inspection, two additional consultant psychiatrists had been appointed; a principal social worker was also appointed in addition to the two existing psychiatric social workers, and a further two were due to take up duty. A principal psychologist had accepted a position and there were two occupational therapists employed with more due to take up approved positions.

Some progress was being made in modernising current practice, with the establishment of three fully staffed multi-disciplinary teams and plans to increase this number to a maximum strength of five teams. The extra multidisciplinary teams had improved the quality of treatment for patients. Following the establishment of five multi-disciplinary teams, attempts will be made to develop sectorisation within the service, particularly in the Eastern region where 63% of admissions came from.

A new Director of Nursing had been appointed and a new triage system had been established for patients on the waiting list. Patients with severe illness were given priority.

In the 2002 Report, the Inspectorate noted two deaths in the hospital, one of a twenty-year-old male by suicide and the other of a thirty-five year-old male. The results of the inquest in the latter case were awaited. There was one death by apparent suicide of a female patient prior to this inspection; the result of the inquest was awaited.

There were no research projects governed by the Clinical Trials Act 1987 — 1990 undertaken in the Central Mental Hospital. No patients were placed on one-nurse to one-patient special nursing supervision or prescribed ECT therapy in 2002.

There were 644 recorded episodes of seclusion involving 60 patients at the hospital in 2002; a marked reduction from 785 episodes involving ninety-five patients in 2001. An appropriate seclusion register was maintained and nursing observations were appropriately recorded. The consultant psychiatrist on duty reviewed each episode of seclusion on a daily basis. Access to the seclusion rooms, which were in Ward 1, was through the ward corridor which allowed little privacy for patients. Patients placed in seclusion should have unrestricted view of a clock. However, the Inspectorate accepted that this may be difficult considering the structural layout of the ward areas. The seclusion facilities at Unit 1 and Unit 4 were structurally outdated and should be relocated.

There were seven requests for information under the Freedom of Information Act, 1997 in 2002; all appeared to have been dealt with satisfactorily. There were no formal complaints made by patients or patients' relatives to the local complaints manager. The management team should ensure that appropriate information was given to patients about their rights under the Mental Treatment Act, 1945 and amending legislation.

Since the 2002 inspection, accident and incident reporting had been classified according to seriousness of outcome. In 2002, there were 26 accidents to patients; 19 resulting in minor injury and three deemed serious. There were six accidents to staff; three deemed serious and two resulting in minor injury. There were eight recorded assaults on patients by other patients; five resulting in minor injury. There were 19 recorded assaults on staff, five resulting in minor injury and two deemed serious.

A number of clinical files were examined. Each newly-admitted patient had a full psychiatric evaluation, including comprehensive admission notes, mental state examination and clear immediate management plan appropriately documented. On one file, the Inspectorate found no written note of the physical examination of the patient on admission. Some of the files were rather bulky and it was difficult to find pertinent and up-to-date information. Written instructions and filing of documentation within the record was required. The storage of loose clinical material at the back of the file should be reviewed. Risks associated with the storage of material in this fashion were delays in accessing information or lost or misfiled information. Copies of discharge summaries were available within the medical file and the copies of discharge reports examined were comprehensive.

The written policy for ordering, prescribing, storing and administration of prescribed medicines was under review at the time of this visit. Individual prescriptions examined were all legible. On a number of cards examined, the Inspectorate noted an increased risk of drug error where discontinued prescriptions were greater in number than current prescriptions. The drug administration recording card had provision for the nurse's signature in full and this was appropriately recorded. User friendly written information on prescribed medicines should be made readily available for the information of all patients.

All policies, procedures, protocols and similar documentation were under review. Some policies, for example the admission policy, was dated 2002 and unsigned with no implementation date or review date stated. There was a detailed and comprehensive fire policy, which was undated. A computerised index of all policies should be kept and revised and superseded policies should be removed from the clinical areas, with one copy kept in a central file for future reference.

There was a detailed safety statement for the hospital dated January 2003 and a site-specific safety statement for each unit dated July 2001. The last safety audit at the hospital appeared to be July 2001.

The nursing model in use at the hospital was a self-care programme adapted for a secure environment. The standard of documentation examined was variable. All entries were accurately dated; time of entry should be recorded using the 24-hour clock. Nursing records should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment.

RECOMMENDATIONS

It is recommended that:

1. The few remaining patients detained at the hospital under Section 207 of the Mental Treatment Act, 1945, deemed to be so fit, be transferred back to their local referring psychiatric services.
2. Unit 4 close and the patients re-located to the vacant Unit A.
3. The bathroom and toilets at Unit 2 and the bedrooms, toilets and seclusion rooms at Unit 1 be refurbished and redecorated.
4. The kitchen at Unit 1 be upgraded and the adjoining dining room be made less institutional in appearance.
5. A decision be made on the future of the original building, whether it should remain as a patient care area or be replaced.
6. The seclusion rooms at Unit 1 be closed and more appropriate facilities be provided; the seclusion policy and procedure at the Central Mental Hospital be reviewed and revised.
7. The low-secure residence on the hospital grounds be redecorated.
8. The recommendations of the Review Group be implemented.

CENTRAL MENTAL HOSPITAL — SECOND 2003 INSPECTION

INSPECTED ON 4TH NOVEMBER 2003

GENERAL DESCRIPTION OF THE SERVICE

The Central Mental Hospital comprised the core element of the Irish Forensic Psychiatric Service. Five multi-disciplinary teams were based there and provided an in-reach service to all the prisons and places of remand in the Eastern region, day facilities at Usher's Island in Dublin and consultancy and advice to other prisons and to local psychiatric services.

GENERAL COMMENTS

The Central Mental Hospital served two unrelated groups of patients, one from the prison system and the other from the mental health service for which it was totally inappropriate. The use of the hospital for mental health services was through the provisions of Section 207 of the Mental Treatment Act, 1945 and, more recently, through Supreme Court approval of its usage for accommodating patients under Section 208 of that Act. Both provisions were inappropriate in the view of the Inspectorate. However, section 207 had ceased to be used: no patient had been sent to the hospital under its provision in the past 10 years. The use of section 208 was equally reprehensible in sending persons neither charged with nor sentenced for any offence to a forensic facility. It was simply a pragmatic solution to a problem for which no adequate services existed in the State — regional secure or forensic care units.

Meantime, the hospital continued to provide accommodation in surroundings that were unacceptable either in environmental or treatment terms. The Inspectorate had reiterated year after year that conditions in the hospital were non sustainable from a human rights perspective and support for this point of view had come from an international source, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment on its two recent visits to the Hospital.

This situation had been acknowledged by the Eastern Regional Health Authority. An advisory group set up by the East Coast Area Health Board had reported on the wide-ranging improvements needed to bring conditions in the hospital into the 21st century. A project team was now examining how these recommendations might be implemented. At the same time, because of delays in moving acutely ill prisoners who were kept in padded cells in the prisons to the hospital, a working group had drawn up and presented to Government a service level agreement between the Department of Justice, Equality and Law Reform and the Department of Health and Children to improve capacity and treatment turnover in the hospital. As an essential adjunct to this, section 207 and 208 patients should be accepted back by their local services. However, these local services had consistently ignored calls to attend case conferences to discuss how this might be affected. The legal representatives of one patient had now brought the matter before the courts.

All seclusion episodes were authorised by consultants. However, the Inspectorate was concerned about the very high level of seclusion practised in the Hospital and the appalling condition of the seclusion rooms. There must be some improvement in these matters.

RECOMMENDATIONS

It is recommended that:

1. The recommendations of the Advisory Group be implemented as quickly as possible.
2. All appropriate means be invoked to have suitable patients returned to their local services.
3. Regional intensive care units be established to abolish the practice of sending patients from mental health services to the hospital.
4. The use of seclusion be reduced and the practise of placing newly-admitted patients to the seclusion rooms cease.

PSYCHIATRIC UNIT, ST VINCENT'S HOSPITAL, ELM PARK —

2003 INSPECTION

INSPECTED ON 22 OCTOBER 2003

IN-PATIENT CARE

In-patient care was provided at the 22-bedded St. Camillus psychiatric unit, St. Vincent's Hospital, Elm Park. Nineteen beds were in operation, three beds remained closed due to staffing difficulties.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	1	—	3	1	5	83.3
3-12 Months	—	—	—	—	—	1	1	16.7
1-5 Years	—	—	—	—	—	—	—	—
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	—	1	—	3	2	6	100
% of Total	—	—	16.7	—	50.0	33.3	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
1	1	1	3	—	—
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
—	—	—	—	—	6

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	3	16	19
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	3	16	19

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate	No.	% of all	Voluntary	non-voluntary		
169	N.A.	56	33.1	97.0	3.0	173	0

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	55	187
Day Centres	—	—	—
Out-patient clinics	1	197*	Not available

*No. of out-patient clinics held in 2001

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
—	—	—	—	—	—

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
13.33	5	22	2	5.25

COST

The cost of the St. Vincent's Hospital Service was €2.5 million in 2002.

GENERAL COMMENTS

This unit was due to close and the new 54-bedded unit was ready to be occupied. This new unit would also replace the current Area 2 acute admission units at Vergemount Hospital and would also take on a catchment responsibility for this area; with six beds for the psychiatry of later life and three beds for eating disorders which, when not required for this purpose, would be available for general usage.

The Inspectorate noted that the negotiations to open the new 54 bedded unit at St. Vincent's Hospital had not concluded: this was disappointing.

There were four involuntary admissions to St. Camillus's Unit, in 2002: one was re-graded to voluntary status during the course of hospitalisation. Eleven per cent of all admissions to the St. Camillus Unit were to the eating disorders programme, 19% were to the psychiatry of later life beds, 25% were admitted following an overdose or incident of self harm and 45% were admitted via the Accident and Emergency Department at St. Vincent's Hospital. One patient admitted to the unit in 2002 was aged under 16 years.

During 2002, there were 343 general adult liaison consultations and a further 52 consultations by the psychiatry of the later-life team in the wards of St. Vincent's Hospital: 19 patients were admitted to the St. Camillus unit following liaison assessment. The statistical data relating to liaison consultations was incomplete as there were no figures available for the accident and emergency consultations: this required review. In 2002, 17 patients were transferred from the St. Camillus unit to other in-patient care settings; 15 of those to St John of God Hospital, one to the Mater Hospital and one to Vergemount clinic. Of the 173 discharges from St. Vincent's Hospital in 2002, three patients took their own discharge against medical advice and were given out-patient appointments, if deemed clinically appropriate.

There were 405 first referrals and 685 return reviews undertaken by the Department of Later-Life Psychiatry. This specialised service had access to four in-patient beds at St. Vincent's Hospital and there were 32 admissions to those beds in 2002. The service also had access to beds at the St. John of God Hospital, Stillorgan, where there were 52 admissions. There were three admissions to long-stay facilities at Units D and E in Vergemount Clinic, Clonskeagh from the later-life service and 20 admissions to the two respite beds at Cois Ceim elderly care unit, Tivoli Road, Dún Laoghaire. The day hospital for the later-life psychiatry service at Carew House, adjacent to St. Vincent's Hospital which opened in 2002 continued to function satisfactorily. There were 12 patients on the register at the end of the year with 23 referrals to the new service between September and December 2002.

There was one complaint made by patients or patients' relatives to the local complaints manager in 2002. Information relating to freedom of information requests specific to the Department of Psychiatry was not available. There was some difficulty within St. Vincent's Hospital in separating such requests by specialty. Local management should monitor the handling and outcome of all informal complaints at the St. Camillus Unit to ensure minimum delay and note any quality implications arising from the complaint. There were no

research projects governed by the Clinical Trials Act 1987-1990 undertaken in the St. Camillus Unit.

Five patients at the unit were prescribed ECT in 2002. It was noted that the number of patients prescribed ECT was declining. There were no ECT facilities at the St. Camillus Unit; patients who required this treatment were brought to the operating theatres at St. Vincent's Hospital. There was, however, no protected time for ECT, resulting in patients waiting for long periods. This, of course, will change with the opening of the new integrated Department of Psychiatry which has its own ECT suite.

There were 58 accidents to patients and 16 accidents to staff at the St. Camillus Unit in 2002: none of the accidents were deemed serious. Of the 11 recorded assaults on staff, five resulted in minor injury.

In 2002, 15 patients were placed on one-nurse to one-patient special nursing supervision and there were 197 episodes of special nursing involving duty spans of 10 hours or more. As special nursing observation was a significant event, it should be audited at six-monthly intervals. A minimum data set should include reasons for observation, specific levels of observation, length of time observed and any untoward incidents. Records should also be kept of the patient's views of the process. The nurse's views of the process should be collected regularly and used to improve the implementation of observation.

All patients must be informed of their legal rights under the Mental Treatment Act, 1945: verification that this information had been given should be recorded in the patients' case notes. Voluntary patients should be told that if they wish to leave hospital they must discuss this with their consultant or in his/her absence the Clinical Nurse Manager.

Written instructions on filing of documentation within the patient's case file was required. Each newly-admitted patient had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and immediate management plan were clearly recorded in case notes examined. While there was provision for the recording of a patient's name on each continuation page, it was not always recorded. A number of abbreviations were used in notes examined and there was no local policy on approved abbreviations. Many files had loose clinical material stored in the back pocket of the file: risks associated with this, included delays in accessing information and loss of clinical information. The ICD diagnosis was not always stated. The signature of the doctor making the input was in some instances illegible. Also, designation was not always recorded. Ideally, the doctor should write his/her name in capitals, sign the entry and record his/her designation. This would enable identification of the practitioner in the future.

To ensure appropriate integration of the St. Camillus and Vergemount services into the new unit, policies, procedures, guidelines, risk assessment and risk management tools required review. Similarly, an agreed integrated nursing care plan was required. The quality of nursing documentation at the St. Camillus unit was satisfactory: records contained relevant information relating to the observation of the patient, all entries were accurately

dated and timed using the 24-hour clock and signed in full by the nurse making the entry. Ideally, nursing records should reflect the involvement of patients in planning and making choices and decisions about their care and treatment. This was an ideal opportunity to introduce a primary nursing care system and to involve patients directly as partners in their treatment and recovery. The discharge plan and nursing record of care from St. Vincent's Hospital should be incorporated into any new agreed nursing records.

RECOMMENDATION

It is recommended that negotiations concerning the human resource/industrial relations issues be brought to a conclusion as a matter of urgency to enable the new unit to open as soon as possible.

WICKLOW MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 7th AUGUST 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 100,004 was divided into three sectors as follows:

Sector	Population
North County Wicklow	33,631
Mid County Wicklow	32,076
South County Wicklow	34,297

This service catered for Co. Wicklow through an acute in-patient and continuing care service at Newcastle Hospital and a limited community service.

IN-PATIENT CARE

In-patient care was provided with 90 beds in 2002, 30 of these beds were de-designated in 2003. In-patient care is now provided in 60 beds in two integrated units.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	7	3	6	1	18	27.2
3-12 Months	—	1	—	2	3	—	6	9.1
1-5 Years	—	—	1	7	4	8	20	30.3
> 5 Years	—	—	—	11	6	5	22	33.3
All Lengths of Stay	—	2	8	23	19	14	66	100
% of Total	—	3.1	12.1	34.8	28.8	21.2	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
19	25	—	8	4	—
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
—	6	—	4	—	66

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	25	18	43
Temporary	2	1	3
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	27	19	46

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
495	4.9	139	28.1	89.9	10.1	464	5

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	20	176
Day Centres	4	161	287
Out-patient clinics	9	258*	1,139

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
4	22	5	60	—	—

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
10	13	70	46	5.5

COST

The cost of the Wicklow Mental Health Service was €8.5 million in 2002.

GENERAL COMMENTS

Although the Wicklow Mental Health Service provided care in congenial surroundings, both in the community and at Newcastle Hospital, it was urgently in need of serious developmental attention and although there was a seven-year plan dating back to 1999 some urgent initiatives were now called for. Community-based facilities were either rudimentary or lacking in the sectors. The establishment of sub-specialties was essential and the future role of Newcastle hospital and its campus needed clarification. In common with a small and decreasing number of services, acute in-patient care was delivered in a single specialty, stand-alone psychiatric hospital, contrary to the policy, dating back to the Report of the Commission on Mental Illness in 1966, to locate acute care in general hospitals. As far as Wicklow was concerned, the problem was compounded by the fact that the county did not have an acute general hospital. With an enhanced community service to south Wicklow, the acute bed needs of that sector should be minimal and, with enforced admission policies to exclude needless admissions, as for example, for alcohol detoxification, acute beds needs should be met by a modest allocation at St. Colmcille's Hospital. As part of this initiative, the liaison/consultant services to that hospital should be rationalised between Wicklow and Cluain Mhuire, with the balance of responsibility falling on the Wicklow service, on the assumption that the majority of patients in that hospital come from Wicklow rather than from Dublin.

Alternatively, and in line with the Hanly proposal for the regionalisation, consideration could be given to regionalising all acute in-patient services for the East Coast Area Board psychiatric services in the new psychiatric unit at St. Vincent's Hospital, Elm Park and the deployment of staff to extensive community services.

There was no day hospital or mental health centre in the entire service although there was a long-established and high-quality day centre with associated activities at the Lincara centre in Bray and a new attractive day centre had recently opened in Arklow.

The Kilmullan Centre in Newcastle tried to cater for inpatients and, at the same time, serve as a mid-sector day centre. There was no high-support community-based residence in the catchment area, although there were plans to convert the Sonas House in Arklow for this purpose. Sector headquarters were required in both mid- and south- Wicklow and the role of the newly-acquired Trudder House should obviously be considered in this context. These deficiencies prevented a more community-orientated service with the potential to engage in more outreach and home-based activity being put in place. The small number of nursing staff and the difficulties experienced in filling vacancies through recruitment compounded the problem. The service had shown admirable initiative in recruiting nursing assistants, thus allowing nurses to tackle more professionally skilled and rewarding tasks in line with their training. There were two social workers and the equivalent of two whole-time psychologists but no occupational therapist.

There were three sectors and only two permanent consultants in the service. In line with other services of similar catchment size, there should be specialised services for later-life and rehabilitation psychiatry with consultant-led teams for these sub-specialisations. The issue of liaison/consultation to St. Colmcille's Hospital also needed to be addressed.

Although the three community residences on the Newcastle campus were of high quality they would be better situated in and integrated with local communities. The Avonmore Ward appeared to act as an annex to local nursing homes for elderly patients they were unable to manage. This emphasised the need for a specialized later-life service to provide, inter alia, a consultant service to these nursing homes, an acute assessment service in a small numbers of beds in St. Colmcille's Hospital and a liaison continuing care service in conjunction with the generic services for the elderly in the area. In the meantime, the Inspectorate saw no impediment to de-designating the Avonmore Ward.

The standard of the existing physical structures in the service was of high quality: community residences were well furnished, equipped and maintained. Equally, the quality of documentation of policy and procedures, including information supplied to patients was similarly impressive.

Three patients, one female and two male, were interviewed to ascertain their views of the psychiatric services provided; all were of voluntary status and had previous admissions. All patients were pleased with the courtesy and helpfulness of the staff, were introduced to the professional team responsible for their care, and knew the name of their consultant psychiatrists. They were satisfied with the frequency of consultation with their psychiatrist and the ease of accessibility to them. None of the patients were aware if they had individual nurse care plans or if any nurse was primarily responsible for their care. Two patients had access to the hospital booklet and were pleased with the information given to them about their illnesses and the prescribed medication. They would appreciate, however, having written information available to them. One patient was not sure if her rights under the Mental Treatment Act, 1945 and amending legislation were explained to her. All patients felt that the hygiene and cleanliness of the ward, particularly the bathroom and toilets was excellent. One patient had a reservation about the industrial therapy centre; she found all activities "very boring". When asked how the service could be improved, one suggested, they should have greater access to psychologists and counselors, the second patient suggested that the therapeutic activities provided should be reviewed.

RECOMMENDATIONS

It is recommended that:

The future of this service is extensively scrutinised giving particular attention to:

1. Relocation of acute in-patient services to a general hospital setting.
2. Adding a fourth sector.
3. Establishing specialised services for the elderly, rehabilitation and liaison/consultation.

4. Strengthening the physical and human resources of the sectors to introduce more community-directed delivery of care.
5. Integrating the care of the elderly in Newcastle Hospital with the generic care of the elderly programme in the county.

SOUTH-WESTERN AREA HEALTH BOARD

DUBLIN SOUTH CITY MENTAL HEALTH SERVICE — (AREA 3)

PSYCHIATRIC UNIT, ST. JAMES'S HOSPITAL — 2003 INSPECTION

INSPECTED ON 25 NOVEMBER, 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 97,000 was divided into two sectors as follows:—

Sector	Population
Camac	37,000
Owendoher	60,000

This service provided mental health services through a limited community service and in-patient care at St. James's Hospital. There was also a specialist service for the elderly with a day hospital located in St. Patrick's Hospital.

IN-PATIENT CARE

In-patient care was provided at the Jonathan Swift Clinic, St. James's Hospital which had 51 beds.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	2	21	8	3	2	36	73.5
3-12 Months	—	—	5	3	2	—	10	20.4
1-5 Years	—	—	—	2	—	—	2	4.1
> 5 Years	—	—	—	—	1	—	1	2.0
All Lengths of Stay	—	2	26	13	6	2	49	100
% of Total	—	4.1	53.1	26.5	12.2	4.1	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
2	17	1	13	5	1
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
3	2	1	2	2	49

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	19	22	41
Temporary	2	5	7
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	21	27	48

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
557	5.7	172	30.9	90.8	9.2	566	1

*Per 1,000 population

COMMUNITY FACILITIES

DAY FACILITIES

	Number	No. of Places	No. of persons attending
Day Hospitals	1*	40	187
Day Centres	1	13	10
Out-patient clinics	1	420	7,320

*Day Hospital for Later-Life Psychiatry (St. Patrick's Hospital)

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
4	17	1	10	2	20

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
12	9	55	N/A	13

COST

The cost of the St. James's/Area 3 Mental Health Service was €8.9 million in 2002.

GENERAL COMMENTS

While the Area 3 mental health service retained some historical links with St. Patrick's Hospital, the Inspectorate understood that the service may devolve to autonomy before long. General adult services provided a limited community service and an in-patient facility at the psychiatric unit at St. James's Hospital. The community-based staff were employed by St. Patrick's Hospital.

From January 2004, this catchment area would be enlarged to three sectors and a population of almost 133,000 by including the Drimnagh sector from the Dublin South West (Areas 4 & 5) service. Of these three sectors, only the Camac, will have a sector headquarters and a limited community-based day hospital for minor illnesses. The in-patient unit would continue to offer day care to the Owendoher sector. The Drimnagh Sector day service needs would be met from St. Martha's. The Eastern Regional Health Authority and the Dublin City Council owned a building plot in the Terenure/ Harolds Cross area which, were the funds available, could provide for some of the community needs of this sector. However, nothing of this nature would be available to the Drimnagh sector. These were serious limitations to the service and no solutions were to hand in the present financial climate.

The Jonathan Swift Clinic at St. James's Hospital in-patient unit was unsatisfactory in many respects: the design had taken no account of the need for observation requirements, for adequate safe room provision, for interview rooms and for numerous other facilities consonant with the needs of a modern acute psychiatric unit. The existing space was poorly utilised, with the central courtyard not used for recreational purposes. The ground floor would have been more suitable for the acute ward rather than the day service which now occupied part of it. A disproportionate amount of the unit space was used for purposes other than in-patient care and thought might be given to addressing this.

The later-life service had suffered a set-back by the closure of Emmet Ward in St. Patrick's Hospital, which had provided 24 beds for continuing care. It had been closed for financial reasons and because St. Patrick's Hospital had been keen to convert it exclusively to acute care. Existing patients had been transferred to other psychiatric hospitals, but, some more difficult to manage persons either had not been accepted or had been returned. As a consequence, a majority of the nine beds in the acute assessment ward, Conolly Norman, were occupied by long-stay patients. This experience had highlighted the need for an environmentally designed intensive care facility, on a regional basis, or at least in the South-Western Area Health Board, to accommodate very disturbed elderly patients suffering from organic brain disorders and aggressive behaviour. The location of the day hospital for the Later-Life Psychiatric Service in St. Patrick's Hospital was unsatisfactory and it was hoped to move it, on a temporary basis, to the Dean Swift Clinic when, and if, the Owendoher day hospital moved to a community base. Ultimately, it should be provided, free-standing on the St. James's Hospital campus.

A liaison service to the accident and emergency department and to the general wards had been created, but this was administered by St. James's Hospital rather than by the Health Board. There was good co-operation between the two service components and the new service appeared to be working well. Detailed statistical data on the number of liaison consultations and outcomes should be kept and reported on annually.

A new post had been created catering for two quite un-related sub-specialties, the homeless mentally ill and peri-natal psychiatry. The first half of this responsibility would cover the South-Western Health Board Area and the second, the Coombe Women's Hospital. The Inspectorate would have preferred that the needs of the homeless mentally ill would have been provided on an integrated, co-ordinated basis with the St. Brendan's homeless service.

Each newly-admitted patient to the Jonathan Swift Unit had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and clear, immediate management plan appropriately recorded in medical notes examined. The case note procedure was an integrated one, with nursing care plans and medical clinical notes in the same folder. The case notes themselves were poorly structured and the top sheet did not carry boxes for numerical ICD diagnosis. Written instruction on filing of documentation within the clinical record was available. While there was provision for the recording of the patient's name on each continuation page, this was not always recorded. The signature of the doctor obtaining the information was, in some instances, illegible. Also, designation was not always recorded. Ideally, the doctor should write his/her name in capitals then sign the entry and record his/her designation. This would enable identification of the practitioner in the future. In some files examined, there was considerable storage of loose clinical material which posed a risk of lost or misfiled clinical information.

In 2002, 51 patients were admitted on temporary certificates to St. James's Hospital, 24 male and 27 female. Eight patients admitted as voluntary patients were re-graded to involuntary status during the course of their hospitalisation. Information relating to the number of involuntary patients re-graded to voluntary status or on the number of extensions (if any) of involuntary admission orders during the year was not available to the Inspectorate. These matters should be attended to. During 2002, two patients were transferred from this service to the Central Mental Hospital under Section 208 of the Mental Treatment Act, 1945.

Nine patients were prescribed ECT at St. James's Hospital during 2002; all arrangements for ECT, including the consent form, were satisfactory. Guidelines for the administration of ECT were prominently displayed in the treatment area. The clinical notes should record discussions with the patient on the nature of the procedure, including the risks and benefits. There was a pre- and post-procedure ECT checklist and vital signs were recorded pre- and at regular intervals post-ECT. A physical examination of the patient was appropriately recorded prior to treatment and the assessment of clinical outcome was recorded after each ECT treatment.

In 2002, there were 43 recorded accidents to patients; one was deemed serious. There were 15 recorded assaults on patients by other patients, three resulting in mild injury and two recorded assaults on staff resulting in no detectable injuries.

There were five formal complaints made to the local complaints manager and six requests under the Freedom of Information Act, 1997. All appear to have been dealt with satisfactorily. During 2002, 19 patients were placed on one-nurse to one-patient special nursing supervision and there were 161 episodes of special nursing supervision — a marked increase from three patients and 28 episodes the previous year. This may reflect the difficulty being experienced by the service in transferring patients from the unit to the special care unit at St. Brendan's Hospital.

Information on patients' rights under the Mental Treatment Act, 1945 and amending legislation was prominently displayed at the Jonathan Swift Unit but there was no indication that this information had been brought to the attention of patients. All patients irrespective of their status must be informed of their rights. Ideally, this information should be given in writing with a verbal explanation of the contents. An entry should be made in the patient's clinical documentation that an explanation had been given with an indication of the patient's understanding. A method of informing patients of hospital charges should be introduced.

There were no research projects undertaken in this service governed by the Clinical Trials Act, 1987-1990.

The 'Roper' model of nursing was in operation and care plans were reviewed weekly or more often if deemed necessary. Nursing assessment interviews were well recorded on all records examined. The biographical data sheet for each admission, recording legal status, next of kin, name of GP, history of allergies, drugs sensitivities and records of patients height, weight, temperature, pulse, respiration, blood pressure and urine testing were all completed satisfactorily. All entries in the nursing documentation were accurately dated: time of entry should be recorded using the 24-hour clock. The records should reflect the involvement of patients in planning and making choices and decisions about their care and treatment.

A written drugs policy and procedure, which included written instructions on the use of prescription cards, was available. The standard of prescription writing on the cards examined was satisfactory: all prescriptions were signed and dated individually and the discontinuation column was completed. While the drug administration card had provision for the nurse's initials, a signature bank was maintained with sample signatures of all nurses administering prescribed medicines to patients. Prescribed medicines were stored appropriately and the transport system for medicinal products between the units was satisfactory. Emergency equipment was stored in a locked room and was checked and signed off weekly.

All staff in this service wore identifying name badges stating their designation within the multi-disciplinary team. There was a comprehensive policy for patients absent without

official leave which was reviewed in November 2002. There was a comprehensive set of policies and procedures which was very general hospital oriented, although some practice guidelines were available specific to the Jonathan Swift Unit. While the Jonathan Swift Unit was clean and well-maintained, it was very austere in appearance. Efforts should be made to make it more homely with appropriate redecoration and furnishings.

There was a comprehensive smoking policy in the service. All of the community residences within the catchment area were non-smoking for a number of years. The smoking area at the Foynes Unit was also the common day-room; there were no specific and isolated smoking areas. This would require attention, as non-smoking patients would require a non-smoking environment in all common and day areas.

Three patients, two male and one female, were interviewed to ascertain their views on the level of care provided with a view to obtaining suggestions for improvement in care provision. All were of voluntary status. While patients were satisfied with the courtesy and helpfulness of the staff they were not happy with the admission procedures; apparently all admissions to this unit came through the A&E Department of the general hospital and patients spent long hours waiting to be admitted. All patients knew the name of their consultant psychiatrist and had access to them on a regular basis. However, one patient felt he was sometimes ignored by staff. They were satisfied with the information given to them in relation to the medical condition, including medication and treatment. However, one patient felt that his presenting psychological problems had not been explained to him; he felt that there was some doubt as to what his diagnosis was.

Patients were generally satisfied with the quality and quantity of the food provided. They were satisfied with aspects of privacy and dignity relating to their care. However, one patient disliked consultations where a multi-disciplinary team was present; he would prefer one-to-one interviews. Patients reported satisfaction with the occupational therapy provided. However, one patient felt there was a lack of occupational therapy at the weekends which caused boredom.

One patient had been referred to the social worker who spent one hour with him each weekday, talking his problems through with him; he was particularly pleased with these sessions. When asked how they would like to see the services improved, all patients suggested that there should be some procedure for admission to the unit without having to go through the Accident and Emergency Department of the general hospital.

RECOMMENDATIONS

It is recommended that:

- 1 The requisite physical and Professional infrastructure to provide outreach community-based care in all three sectors be established.
- 2 A specialised rehabilitation team be recruited.

- 3 Thought be given to reconfiguring the space in the Dean Swift clinic to make better use of space and improve patient observation and comfort, including alternative location of the day unit.
- 4 Suitable accommodation be acquired for the continuing care needs of the later-life service.
- 5 Provision be made for the location on the St. James's campus of the day hospital for the later-life service.
- 6 Statistical data on the activity of the newly-established liaison service be kept and reported on annually.

**DUBLIN SOUTH-WEST MENTAL HEALTH SERVICE, (AREA 4 — 5)
TALLAGHT HOSPITAL PSYCHIATRIC UNIT AND ST. LOMAN'S
HOSPITAL — 2003 INSPECTION**

INSPECTED ON 17 DECEMBER, 2003

GENERAL DESCRIPTION OF THE SERVICE

The population of the catchment area was 277,229 and it was divided into four sectors as follows:—

Sector	Population
Crumlin/Drimnagh/Walkinstown	75,838
Tallaght/Rathcoole	78,596
Ballyfermot/Chapelizod/Palmerstown	68,475
Clondalkin/Lucan	54,320

In-patient care was provided at the Psychiatric Unit, Adelaide and Meath Hospitals, Dublin incorporating the National Children's Hospital (AMINCH) and at St. Loman's Hospital. In addition, a 22-bedded Rehabilitation Unit was located on the St. Loman's Hospital Campus. There were also two undesignated residential units on the St. Loman's campus. Community care was provided through a variety of day and residential facilities in the catchment area.

IN-PATIENT CARE

In-patient care was provided with 72 beds in one psycho-social rehabilitation unit, one long-stay older persons unit and one extended care unit.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	21	12	3	2	39	79.6
3-12 Months	—	1	2	6	—	—	9	18.4
1-5 Years	—	—	1	—	—	—	1	2.0
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	2	24	18	3	2	49	100
% of Total		4.1	49.0	36.7	6.1	4.1	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
1	22	—	6	7	6
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
2	3	1	1	—	49

Status of In-Patients on date of Inspection 2003 — TALLAGHT HOSPITAL

Status	Male	Female	Total
Voluntary	16	22	38
Temporary	8	3	11
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	24	25	49

Status of In-Patients on date of Inspection 2003 — ST. LOMAN'S HOSPITAL

Status	Male	Female	Total
Voluntary	12	8	20
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	12	8	20

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
620	2.2	150	24.2	87.4	12.6	579	1

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	4	59	1,384
Day Centres	3	70	1,050
Out-patient clinics	5	815*	18,210

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
6	31	4	43	3	43

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
28	29	186	82.5	21.5

Cost

The cost of the Dublin South-West Mental Health Service was €18.9 million in 2002

GENERAL COMMENTS

This service, with the largest catchment area population in the country, had two multi-disciplinary teams operating within each of the sectors and shared facilities. The Inspectorate was pleased to report that agreement had been reached between St. Loman's and St. James's services relating to the area boundaries and as a result the Drimnagh sector with a population of 34,000 was scheduled to transfer to the nearby St. James's service in January 2004.

In the late 1990s the Eastern Health Board (now the Eastern Regional Health Authority) disposed of 25 acres of land on the St. Loman's Hospital campus, which were developed for private housing. It was not clear to the Inspectorate if any of the funding raised from this sale was used to develop the mental health services in this catchment area. Forty-one acres remained for redevelopment and a project team was established to devise a plan to ensure the phased development of the hospital campus. This included the demolition of the existing buildings and the provision of new health facilities on campus. It appeared that capital funding was not available for the existing development plan, which included the provision of a number of units for rehabilitation psychiatry, later-life psychiatry, intensive care and area headquarters at a cost of approximately €20m. There were suggestions that the development might be progressed by public/private partnerships but this had not progressed much further either.

The provision of a purpose-built 22-bed psycho-social rehabilitation centre, including the occupational therapy and nursing administration, on the campus of St. Loman's Hospital was a significant development and enabled patients to be transferred from the old hospital Unit F to much improved facilities. This high-quality, bright and cheerful unit was opened in December 2002. The Inspectorate was pleased to report that the unsatisfactory day centre facilities in Clondalkin had closed and patients relocated to upgraded rented premises at St. Brigid's Road, Clondalkin. Ongoing work was required at this facility to bring it up to modern standards. Teach Bán, the 12-bed high support residence which was purchased by the service in 2001 was extensively refurbished and ready for occupation. However, due to staffing difficulties it was intended to commence day programmes at this location first and when the staffing situation improved the house would be used as a supervised community residence.

The St. Loman's mental health service was the first in this country to establish home care or outreach programme which were located in the Clondalkin sector. The Inspectorate noted that the number of admissions from the Clondalkin sector where the home care outreach team was operational was approximately half that of the remaining sectors. It is also noted that there was a shorter duration of stay for Clondalkin admissions with an estimated utilisation of approximately 25% bed capacity as compared to the other sectors. The Inspectorate welcomed the extension of this programme to the Ballyfermot sector. At St. Loman's Hospital, there were plans to transfer patients from Beechhaven to nursing homes, which would facilitate the closure of St. Joseph's Unit and the re-deployment of staff to a third outreach team in the Tallaght sector. The Inspectorate was disappointed to note that the staff recruitment ceiling created limitations and as a result, all funding was not utilised in 2003; this had the effect of slowing down the development and modernisation of this service.

The assessment beds at Aspen Ward for the Psychiatry of Later life service remained closed due to staffing difficulties. The Inspectorate noted that the service was considering using Aspen Ward as a high-observation area and re-locating the elderly assessment beds elsewhere. It was hoped that this plan would not further delay the opening of those badly needed assessment beds. The team consisted of one consultant, one non-consultant hospital doctor and one part-time occupational therapist. This service could only function effectively if an admission unit and a day hospital were both in operation. As it would be five years or more before a day hospital could be located on the site of the Adelaide and Meath Hospital, the Inspectorate welcomed the initiative of the board in sourcing a premises close by for use as a day hospital for the Department of Later-life Psychiatry. Additional staffing had been approved and appointed to enable the commencement of day hospital activity. The day hospital was located on the third floor of Sheaf House Exchange Building.

The mental health sector service had re-located its day hospital and day centre from the Glenabbey complex to this premises also. The cost of renting the section of the building was €250,000 per annum. The psychiatric general adult day hospital was located on level five, third floor of the building which was entered through a locked door and accessed by means of a lift. The premises and accommodation was lavish and the suitability of the

facility to deal with acute patients as an alternative to admission (which is the function of a day hospital) was something that needed to be reviewed. Considering the cost of renting these premises, the provision of offices for consultants who had offices some hundred yards away at the Tallaght Unit needed urgent review. These offices might be more appropriately used for the Tallaght outreach home-based team.

There were 41 domiciliary medical assessments undertaken by this service and one occupational therapy assessment in 2002. In addition, there were 148 liaison consultations at Tallaght and 15 liaison consultations at Peamount Hospital. There were 178 new referrals to the service in 2002. The low activity levels for 2002 reflected the absence of resources. Additional resources provided in 2003 had already increased activity levels, with referrals of over 300 up to the day of inspection.

Whilst there was no pressure on acute beds at the time of our visit, this service had experienced pressure on beds throughout the year, due, in part, to the presence of medium- to long-stay patients in the acute unit. There was a need to further develop the community services within the catchment area, particularly in relation to alternative residential provision in the form of low- medium- and high-support community residences.

Nursing recruitment and retention remained a significant problem in this service and hampered development. The situation improved somewhat during 2003 with the recruitment of eight newly qualified and seven overseas nurses. The overseas nurses having successfully completed the adaptation course were assigned to in-patient care areas. However, as in previous years, the service lost Irish trained nurses to provincial mental health services and the gains achieved were not sustained. Gaps in nursing resources were filled by a combination of overtime and the use of agency or bank nurses which was not a satisfactory long-term solution. There were 30 nursing vacancies in the St. Loman's mental health service at the time of this inspection. Management had been given approval to fill 11 of these; apparently the remainder were to be abolished as part of the staff ceiling initiative. The service must consider the introduction of an appropriate skill mix in order to maintain existing services into the future where there was likely to be a continued shortage of appropriately trained nursing personnel. Ongoing in-service training was provided for nursing staff with nurses attending training in manual handling, the prevention and management of violence and aggression, cardiopulmonary resuscitation and foreign body in airway obstruction management on a rotational basis. Nurses from this service were sponsored to undertake nursing degree courses at the three Dublin Universities and the College of Surgeons. A number of nurses successfully completed a course in peer advocacy to help prepare the service for the introduction of a peer advocacy service. Smoking cessation training was also provided for nursing staff.

In 2002, 78 patients were admitted on temporary admission orders to the in-patient unit, Tallaght: 10 patients were re-graded to voluntary status and 10 patients admitted as voluntary patients were re-graded to involuntary during their hospital stay. All of the admissions to St. Loman's Hospital were voluntary admissions. Eight patients had their involuntary admission orders extended during the year. Also in 2002, 13 patients were lodged overnight at the Tallaght Unit but not formally admitted and a further three were lodged

overnight in St. Loman's Hospital but not formally admitted. Two patients were transferred from St. Loman's Hospital to the Central Mental Hospital under Section 208 of the Mental Treatment Act, 1945 during 2002. Of the 579 discharges from the Tallaght Unit 53 patients took their own discharge against medical advice, all patients were offered outpatient appointments if deemed clinically appropriate.

There were no formal complaints made by patients or patient's relatives to the local complaints manager during 2002. There were 13 requests made under the Freedom of Information Act, 1997; all appear to have been dealt with satisfactorily. There were no research projects undertaken in this service governed by the Clinical Trials Act, 1987-1990 during 2002.

There were 71 recorded accidents to patients and six recorded accidents to staff at the psychiatric unit, Tallaght during 2002. Two of the patient's accidents were deemed serious. Of the four recorded accidents to patients and three recorded accidents to staff at St. Loman's Hospital, one was deemed serious. Of the eight recorded assaults on patients by other patients and six recorded assaults on staff at St. Loman's Hospital none were deemed serious. There were 32 recorded assaults on patients and 78 recorded assaults on staff at the Tallaght Unit. Six of the patient assaults and 21 of the staff assaults resulted in mild injury, one staff assault was deemed serious. The reporting systems in use appeared satisfactory.

There were 582 episodes of special one-to-one nursing supervision involving 32 patients in 2002, a substantial reduction from the previous two years.

In 2002, 29 patients were prescribed ECT: the treatment facilities at the Tallaght Unit were satisfactory. Records should be made in the patient's clinical notes of discussions held with the patient on the nature of ECT, the risks and benefits attached to the procedure and a note made that the patient fully understood the risks and benefits explained. The physical examination of the patient prior to ECT treatment was appropriately recorded in the notes. Whilst there was a pre-ECT nursing checklist which was completed satisfactorily a post-ECT checklist and a system of recording observations post-ECT should be introduced. The patient's clinical status was assessed following each ECT treatment and the patient's cognitive functioning was monitored on an ongoing basis and appropriately recorded in the medical notes. Information leaflets should be available which would enable patients make an informed decision regarding the appropriateness of ECT for their circumstances. The leaflet should be evidence based and include information about the risks of ECT and the availability of alternative treatment.

There were 427 new referrals and 202 re-referrals to the occupational therapy service in 2002. As in other disciplines of the St. Loman's service, the occupational therapy department experienced recruitment and retention difficulties and a considerable amount of managers' time was dedicated to recruitment efforts. One senior post in the psychiatry of later life and two outreach posts were filled but a number of other posts remained vacant.

In 2002, 624 patients received a social work service from the six mental health social workers. One third of those presented with homelessness and/or accommodation difficulties. Eight per cent had financial difficulties or problems accessing welfare services; 12% received assistance with managing mental health difficulties and another 12% concerned the children of those attending the service.

In 2002, nine patients were placed in seclusion at the Tallaght Unit and there were 26 episodes of seclusion. Some improvements had taken place in the seclusion rooms at the Rowan and Cedar Units: they were re-decorated, ventilation had also improved and two new observation cameras covering the blind spots in the room installed. A multi-disciplinary review was completed and documented for each episode of seclusion and the nursing and medical documentation was cross referenced to the special seclusion register which was appropriately maintained. Nursing observations at 15-minute intervals were all appropriately recorded. Seclusion authorisations were, for the most part, made by consultant psychiatrists.

The policy for ordering, prescribing, storing and administration of prescribed medicines had been reviewed and updated and was available for staff information and reference. The in-patient psychiatric prescription chart was of a very high standard. All prescriptions were signed and dated individually as was the discontinuation column. The drug administration recording card did not have provision for the nurse's signature in full: however, a signature bank was maintained to ensure easy identification of the nurse in the future. There was provision in the prescription cards for recording drug allergy and drug sensitivity so that information was rapidly available to staff: this was not recorded in all of the cards examined. If there are no known drug allergies/sensitivities this should be recorded, otherwise, it may be viewed that an assessment of such was overlooked.

A selected number of nursing records were examined at the Tallaght Unit. A modified version of the 'Roper' model was in use and care plans were appropriately recorded. The biographical data sheet for each admission was well completed; entries were accurately dated but should be signed in full, with full block lettering alongside the signature of the first entry. The signature should be accompanied by the status of the nurse; time of entry should be recorded using the 24-hour clock. The nursing assessment form, the nursing care plan and nursing evaluations were well completed. There was also a discharge details form which was reviewed at each multi-disciplinary team meeting following each in-patient admission. These records were audited approximately two years ago and should be re-audited with a view to involving patients in planning and making choices and decisions about their own care and treatment. Evaluations of nursing care plans should include the patient's views about progress.

The Crumlin Day Hospital had adopted the 'Tidal' model of nursing with a view to providing a more person-centred approach to nursing care. The implementation of this model was to be continually monitored and reviewed with a view to extending the model to other care areas within the catchment area.

A priority for this service was the replacement of the unsatisfactory facilities at the Ballyfermot mental health centre. The intention was to build a new sector headquarters and day centre. The existing centre required decoration internally and externally, ventilation was poor and the overall facilities were not conducive to the appropriate care of patients and staff.

Clinical files examined were of a reasonable standard. Newly-admitted patients had a full medical evaluation recorded in all notes examined. While there was provision for the recording of a patient's name on each continuation page this was not always done. Records of discussions with patients relating to information given to them about diagnosis, treatment, expected benefits, risks and known side effects of any treatment should be recorded in the medical notes. A new policy relating to risk of violence assessment was under consideration with a scheduled approval date of March 2004. The aim of this policy was that all patients would have a risk of violence assessment completed and updated as necessary and documented in their medical record.

There was a comprehensive policy relating to patients absent without official leave from the Tallaght Unit. However, information was required on how the local search should be organised and a site map should also be available.

The management team of this service met formally and appropriate minutes were kept. In addition, sector management teams were being developed within the four geographical sectors. It was the intention of the service management that responsibility for financial and staff resources would eventually devolve to sector level, although insufficient administrative staff, both at junior and senior level, to manage the financial and administrative staff resource issue may hamper this initiative. The Inspectorate welcomes the re-introduction of the annual report to this service, one of the few services in the country doing so. The management undertook a service review involving wide-ranging consultation with staff, service users, voluntary groups and local health board management. The review examined strengths and weaknesses of service provision with a view to producing a vision for the service for the coming years. The review highlighted lack of funding as a source of frustration along with low morale amongst all those working within the service. There appeared to be broad agreement locally on what needed to be done, how it should be done and what the priorities for the service were. Frustration resulted in the absence of an action plan and the necessary funding to speed up the modernisation process.

The St. Loman's mental health service was chosen as a pilot site for the development of an Information Technology system and monies were allocated for the purchase of hardware; 40 PCs and printers were provided for all locations within the service in addition to training needs assessments among all staff. The final phase would be the exploration and installation of a suitable software package which would provide a patient administration system. Work was ongoing on this project.

The Inspectorate found a good standard of clinical audit with a clear process for dissemination of results. Audits undertaken during 2003 included an audit of the risk of violence

assessment, audit of admission to hospital from two sector services Clondalkin and Tallaght, audit of benzodiazepine and medication prescribing among patients in the acute unit, audit of home care referrals in Clondalkin mental health centre, audit of non-attenders at new patient clinic, audit of cardiovascular status of patients on clobazepam and antipsychotic medication, audit of admissions from the Ballyfermot sector before and after introduction of the home care team and audit of A&E referrals to the acute units.

Policies, procedures and guidelines at the acute unit Tallaght Hospital had been reviewed and updated since our last visit. Policies relating to wards of court and patients' voting rights should be added to the policy manual. A pilot risk management and risk assessment strategy had been introduced in the Clondalkin sector and would in time be rolled out to all of the other sectors. There was a site-specific safety statement signed by the local management committee at the acute unit, Tallaght General Hospital.

The quality of food and the hygiene of the food preparation areas examined at Tallaght Hospital were very satisfactory. A printed menu should be available for patient's information. Some improvements were required to the kitchen area of Beech Haven at St. Loman's Hospital. Meals were provided to patients in this service at socially acceptable times.

Two patients, one male and one female, were interviewed to assess their opinion of the services provided; both were of voluntary status. They were satisfied with the courtesy and helpfulness of staff and the admission procedures. They knew the names of their consultant psychiatrists and had adequate access to them while hospitalised. Both patients were aware of the primary nursing system and knew the name of their primary nurse. They were satisfied with the information given to them about prescribed medication and its long- and short-term effects. One of the patients was not aware of his rights under the Mental Treatment Act, 1945 or on how to make a complaint. Patients were pleased with the hygiene and cleanliness of the ward in general. They were pleased with the quality and quantity of the food provided. One patient had a secure locker and wardrobe for his personal belongings; however, the other patient was not pleased with the security of her personal belongings as she had not received any keys.

Both patients were pleased with the therapeutic activities available. When asked how they would like to see the services improved, one patient suggested that access to the main hospital gymnasium would be appreciated. The other patient suggested that some pictures or paintings for the walls of all patient areas would improve the ambience of the unit. A coffee dock for visitors was also suggested.

RECOMMENDATIONS

It is recommended that:

1. The long-awaited transfer of the Drimnagh Sector to the St. James's service be expedited now that agreement between both services and the South-Western Area Health Board has been reached.

2. Funding raised from the sale of lands at St. Loman's Hospital be used to provide replacement facilities for St. Joseph's and Beechaven at St. Loman's Hospital, in addition to strengthening the necessary community facilities.
3. The assessment beds (Aspen Ward) at AMINCH be opened as soon as possible.
4. The extensively renovated Teac Bán community residence at Newcastle, Co. Dublin be used for that purpose.
5. St. Joseph's Unit be closed as per local management plan.
6. The bathrooms and toilets at Rowan and Cedar Wards at AMINCH be upgraded.

KILDARE/WEST WICKLOW MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 14 OCTOBER, 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 171,196 was divided into four sectors as follows:

Sector	Population
North-East Kildare	35,127
North-West Kildare	26,300
Mid-East Kildare	38,000
Mid-West Kildare	39,740
South Kildare	32,029

This service provided care through a range of community services with in-patient care at Naas General Hospital.

IN-PATIENT CARE

In-patient care was provided at the 30 bed Lakeview Unit at Naas General Hospital in one integrated ward.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	2	2	3	1	—	8	40.0
3-12 Months	—	—	2	1	1	—	4	20.0
1-5 Years	—	2	3	2	1	—	8	40.0
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	4	7	6	3	—	20	100
% of Total		20.0	35.0	30.0	15.0	—	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	8	—	7	—	—
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
—	5	—	—	—	20

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	8	10	18
Temporary	2	3	5
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	10	13	23

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
726	4.2	165	22.7	82.6	17.4	733	—

*Per 1,000 population

COMMUNITY FACILITIES

DAY FACILITIES

	Number	No. of Places	No. of persons attending
Day Hospitals	3	32	630
Day Centres	2	22	24
Out-patient clinics	15	585*	607

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
3	16	1	6	2	30

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
17	8	95	26	10

COST

The cost of the Kildare Mental Health Service was €6.5million in 2002.

GENERAL COMMENTS

There were now five sectors in this service and there was talk of creating a sixth. All sector teams were headed by a permanently appointed consultant psychiatrist. All sectors, except Naas, had sector headquarters and day facilities, two of these recently created in the new generic health centres at Celbridge and Athy. There were plans to erect a sector headquarters for the Kildare North-East sector in the grounds of Boycetown House, from the proceeds of the sale of Auburn House. The Inspectorate was disappointed that Naas, the largest town in the catchment did not yet have a sector headquarters/ day hospital/mental health centre. However, arrangements were in place to acquire temporary premises for this purpose at St. David's in the centre of the town. There would eventually be ample accommodation at a new, major health care development on the site of the former Naas military barracks.

Community residential accommodation remained limited throughout this service, although a new spacious house, Clonree, at the edge of the Curragh had been purchased in the past couple of years. This was in good decorative and structural order and had the potential to accommodate approximately 14 residents — it had been a small hotel and was fitted with an external fire escape which should have little difficulty in meeting fire and safety requirements. However, the staff resources to open it were currently lacking. The house at Castledermot continued to operate as a day centre, despite its obvious potential as a support residence. The Inspectorate discussed this matter with the relevant staff whose objections to this use — remoteness from the town centre, heavy traffic on the roads etc — they believed to be unfounded. However, the need for high-support accommodation was not as urgent as two or three years ago when there were extra beds in the corridors of Lakeview unit. The situation had eased with the opening of Bramble Lodge, the acquisition of Lareen in Maynooth, (which formerly belonged to the St. Loman's service) and the transfer there of long-stay patients from the Lakeview unit and the strengthening of the sector teams to enable more community-oriented care to evolve. Nonetheless, with a growing catchment population there will be a requirement for further community residential accommodation. Most of the out-patient accommodation was unsatisfactory, particularly in Newbridge where efforts were being made to replace the existing premises.

The hospital developments at Naas General Hospital included a new out-patient department with an allocation for psychiatry, replacing the current unsatisfactory arrangements. However, the ultimate ambition should be to integrate this element of service provision in a primary care setting. Through the recruitment of social workers, psychologists and occupational therapists, the teams, generally speaking, had taken on a multi-disciplinary composition. However, nurse numbers were limited and there were eight vacancies which were required for current service needs. Nine additional nurses were required to staff Clonree House. This shortage meant that the high-support premises, Clonree, could not open and it also curtailed the introduction of intensive outreach programmes of care.

Consideration was being given to extending the ground floor area at the Lakeview unit to provide more space. This would entail cutting into the courtyard area, which would be unhelpful as the courtyard/garden space was quite limited. At the same time, the roof garden to which the unit had access was not used and the Inspectorate felt that it should be. The courtyard garden was badly in need of care.

Documentation examined was generally satisfactory, although some suggestions were made for improvement. Case-note structure and organisation was generally adequate and some records inspected at random gave reasonably detailed intake assessments and care planning information, though there was little evidence of user/carer involvement. The front or top sheet provided for ICD numerical diagnostic coding, but the code was not entered.

All team provision in the service was for general adult psychiatry, with no specialised services. However, staff did say that they would welcome and seek a specialised service for both later-life and rehabilitation psychiatry.

Liaison services were provided on an “on call” basis. Currently, there were up to 2000 such requests, mainly from A&E and, as the new A&E facility had begun functioning it was likely that these demands would increase. An interviewing room in A&E was available to psychiatry services for evaluation of patients in privacy. The Inspectorate commented in their 1993 report on the comprehensive records that were kept of all liaison consultations to Naas General Hospital. However, over the years, the system was not maintained, resulting in no records available for the years 2000 or 2002. A recording system was reintroduced earlier this year. There were 934 liaison consultations at the accident and emergency department to date, a marked increase from the 309 consultations in 1992; there were approximately ten further referrals to the mental health service from the general wards at Naas General Hospital.

There were 127 involuntary admissions to this service in 2002; ten patients admitted involuntarily were re-graded to voluntary status during the course of their hospitalisation. The involuntary admission rate to the Naas service remained at approximately 17.4%.

Of the 733 discharged from the service in 2002; 27 took their own discharge against medical advice. All patients taking their own discharge were offered out-patient medical appointments.

The facilities for ECT at the Naas unit were satisfactory as was the documentary procedures relating to it. Twenty-three patients were prescribed ECT in 2002. None of the patients’ resident in the unit at the time of our visit had been prescribed ECT; therefore, clinical records relating to the procedure on this occasion were not checked.

Fourteen patients were placed on one-nurse to one-patient special nursing supervision and there were 540 spans of special nursing supervision during 2002, compared to approximately 265 spans for the previous two years. New guidelines for nurses carrying out special nursing observations had been introduced since the previous visit. As special nursing

supervision was a significant event, it should be audited at six-monthly intervals. This audit should be similar to the one undertaken in the past year on the utilisation of a need for seclusion facilities.

In 2002, there were 83 episodes of seclusion involving 14 patients: the seclusion facilities were structurally appropriate with access to the room through the ward corridor. Some authorisations for seclusion were made by junior doctors and some of the signatures were not very legible. There was a need for all seclusion authorisations to be countersigned by a consultant psychiatrist. Seclusion authorisations were for short periods and usually the hours were stated. A revised seclusion policy and procedure had been introduced since our last inspection. Some documentation in relation to seclusion was cross-referenced to the special seclusion register. The nursing care plan included information of events prior to each seclusion episode and 15-minute observations were appropriately recorded. Patients whilst in seclusion should have an unrestricted view of a clock. Information on the patient's response to seclusion during and after the event should be clearly documented in the clinical notes. Multi-disciplinary reviews should be completed and documented for each seclusion episode.

There were no research projects governed by the Clinical Trials Act, 1987-1990 undertaken in the Kildare mental health service. There was one recorded complaint and five requests under the Freedom of Information Act, 1997, made to the local complaints manager in 2002. Management should closely monitor the handling and outcome of all informal complaints to ensure minimum delay and note any quality implications arising from the complaint.

Notices on patients' rights under the Mental Treatment Act, 1945, were prominently displayed on the patient notice board of the Lakeview Unit. A staff member should be assigned to review a patient's understanding of their rights.

There were 12 recorded assaults on patients by other patients and 14 recorded assaults on staff in 2002; none were deemed serious. There were 127 accidents and incidents relating to patients, 67 resulting in minor injuries and none were deemed serious. There were nine recorded accidents to staff resulting in no detectable injury.

Out-patient clinical sessions were held at 15 locations within this catchment area. An appointment system was in operation and there was a waiting list of approximately 51 patients (for all sectors) at the end of the year. All urgent referrals were seen either through A&E or outpatients immediately. There were 585 clinics in 2002, at which 607 new patients attended. Patients on the waiting list were prioritised by consultant psychiatrists according to need, usually at sector headquarters or in the A & E Department of Naas General Hospital. The facilities at the Kildare clinic were unsuitable. However, the service had acquired a new premises at Aras Bríd and were scheduled to re-locate there before the end of 2003. The facilities at the Newbridge clinic remained unsuitable. The clinic should be re-located to an appropriate setting with adequate privacy as soon as possible.

All policies, procedures and guidelines were reviewed during 2002 and a number of approved policies were introduced in June 2003. While policies and procedures in the revised manual were indexed, some were difficult to find: this problem could be solved by numbering pages or separating policies into areas sections. All revised policies and procedures should be incorporated into an audit process to enable assessment of efficacy and compliance. Guidance notes on the management of illicit drug use or drug-related incidents at the unit, setting out the actions to be taken by staff, should be available and included in the policy manual.

The drug medication policy and procedures had been reviewed and updated and included in the revised policy documentation. Revised prescription card and drug-recording cards had also been introduced since our last visit. Generally speaking, prescriptions examined were legible; all were signed and dated individually, as was the discontinuation of prescribed drugs. While the drug administration recording card did not have provision for the nurse's signature in full, there was provision for this at the back of the prescription documentation. This was very satisfactory. Written information for patients on certain prescribed medications was available in the nurses' office and distributed to patients as required. The storage area and transport system for prescribed medical products were satisfactory. The system of administering prescribed medications to patients should be reviewed. The Inspectorate observed two nurses in the nurses' station administering medicines to patients through a hatch, the risks associated with this procedure were obvious; there was no real supervision of the patient to ensure they were taking the medications as prescribed. Ideally, a nurse should remain with the patient to ensure compliance.

A number of medical files were examined. Each patient had a medical evaluation, including admission notes, mental state examination, physical examination and immediate management plan recorded in the notes. The date of record was stated, but time was not clearly recorded in all cases. The patient's name and hospital identification number was not always noted on each continuation page. Whilst all entries were signed, ideally the doctor should write his/her name in capitals, then sign the entry and record his/her designation. There was written evidence of communication with patients' relatives in a number of notes examined. Written evidence of discussions held with patients on medication and other treatments and the obtaining of informed consent should be recorded. Written instructions of filing of information within the record were required. The system whereby loose clinical material was stored in the back pocket of a number of files should be reviewed.

The biographical information recorded as part of the revised nursing care plan was generally well completed. A nursing discharge summary plan for each patient should be added to the nursing documentation. A record was made of the patient's understanding or expectation relating to his/her admission to hospital and provision was made for the patient to sign the assessment interview; however, this was not always recorded. The section for recording allergies and drug sensitivities was completed, where there were no known drug allergies this was also recorded. While all entries in the nursing records were accurately dated, time of entry should be recorded using the 24-hour clock. Nursing records examined

contained relevant information relating to nursing observation of patients and any noted changes in patient’s medical or psychiatric condition.

Three patients, two females and one male, were interviewed to ascertain their opinion of the psychiatric services provided: two patients were of temporary status and one was of voluntary status, all had previous hospital admissions. All patients were pleased with the admitting procedures, were introduced to the professional team responsible for their care and knew the name of their consultant psychiatrist. One patient was particularly pleased with the frequency of consultation with his consultant psychiatrist. All patients were pleased with the courtesy and helpfulness of the nursing staff. Two patients said their psychological problems had been fully explained to them as had the prescribed medications and their therapeutic effects and potential side effects. One patient alleged that her psychological problems had not been explained to her, but that the side effects of her prescribed medications were fully explained to her by the nursing staff. All patients were aware of their rights under the Mental Treatment Act, 1945 and also of the hospital complaints procedures. All patients were aware of the ‘Primary Nurse System’ and felt involved in their caring process.

Patients were pleased with the activities available during the day such as occupational therapy activities, games, art, cooking etc. and found them very helpful. However, one patient found the weekends very boring and suggested activities such as pool, darts etc. He also suggests that there should be more organised walks outside of the unit.

RECOMMENDATIONS

It is recommended that:

- 1. Thought be given to the introduction of specialised services for later-life and rehabilitation psychiatry, and at a later stage, for liaison psychiatry and for the psychiatry of intellectual disability.
- 2. The service proceed with its plans for the extension of community-based sector head-quarters and acute day hospitals in all sectors, with particular emphasis on Naas.
- 3. The Castledermot house be used for residential purposes.

NORTHERN AREA HEALTH BOARD

**PSYCHIATRIC UNIT, JAMES CONNOLLY MEMORIAL HOSPITAL
(AREA 6) — 2003 INSPECTION**

INSPECTED ON 9 JULY, 2003

GENERAL DESCRIPTION OF THE SERVICE

The population of the catchment area was 70,144.

Sector	Population
Blanchardstown (A & B)	70,144

The Area 6 psychiatric service had a total population of 126,656 and comprised four sectors, Cabra, Finglas, East Blanchardstown and West Blanchardstown. It provided acute psychiatric in-patient care for the Cabra and Finglas sectors in St. Brendan's Hospital and for the two Blanchardstown sectors (Unit 9), James Connolly Memorial Hospital and community services through a limited network. In addition, it provided a specialised service for later-life psychiatry on a joint basis with Area 6 through a unified service for the two catchment areas. These services for older people comprise an acute assessment unit in St. Vincent's Hospital, Fairview, continuing care in Unit 3, James Connolly Memorial Hospital, Blanchardstown and a day hospital at the same hospital.

IN-PATIENT CARE

In-patient was provided with 22 beds in one integrated unit

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	10	4	—	—	14	82.4
3-12 Months	—	—	1	1	—	—	2	11.7
1-5 Years	—	1	—	—	—	—	1	5.9
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	1	11	5	—	—	17	100
% of Total	—	5.9	64.7	29.4	—	—	100	

IN-PATIENT POPULATION DIAGNOSIS AT 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	4	1	5	2	—
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
1	1	2	—	1	17

STATUS OF IN-PATIENTS ON DATE OF INSPECTION 2003

Status	Male	Female	Total
Voluntary	7	11	18
Temporary	2	2	4
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	9	13	22

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
261	3.3	84	32.2	88.9	11.1	278	0

*Per 1,000 population

COMMUNITY FACILITIES

DAY FACILITIES

	Number	No. of Places	No. of persons attending
Day Hospitals	1	10	56
Day Centres	2	85	70
Out-patient clinics	7	585*	1,696

*No. of out-patient clinics held in 2002

COMMUNITY RESIDENCES

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
3	32	3	24	4	69

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
23.5	18.5	74.5	41	9.4

COST

The cost of the Area 6 Mental Health Service was €8.9 million in 2002.

GENERAL COMMENTS

The Inspectorate was of the opinion that there were very serious problems with this service. The existing acute admission unit, Unit 9, JCMH was of extremely poor quality and unacceptable for patient care; the Inspectorate had no hesitation in condemning it outright. Patients themselves had made numerous complaints about conditions inside, and more recently outside as building work involving the developments at JCMH proceeded. The land on which Unit 9 rested had been sold and possession would have to be ceded to the developer/purchaser very shortly. The Inspectorate was unable to ascertain the precise date on which this would occur. As the conditions at Unit 9 were unacceptable, this Unit should close and patients be re-located as a matter of urgency.

The new acute psychiatric unit in JCMH was now constructed, commissioned and ready for patient occupation. Unfortunately, there were many design problems and it could not

be occupied by patients as originally planned. The central garden area for the adult unit was overlooked by several storeys of offices and wards. All the window areas of these directly overlooked the Psychiatric Unit garden. The garden for use by patients in the high-observation area in this new unit was a small corner of the total garden space, railed off with twelve-feet-high railings and was also in full view of the wards above, as well as being visible through the railing bars from the central garden area.

The general adult area suffered from innumerable defects: the day-areas, observation-areas and sleeping areas were unsuitable in their present form and would require modification. The space devoted to the unit was considerable but much of it was wasted and unusable for ordinary care purposes. There were individual offices for every consultant, including the consultant for later-life despite this service having its own self-contained service, but very limited accommodation for nurses and no office accommodation for psychologists or social workers. This arrangement was untenable: these offices should be used on a sector basis and shared by professionals. Once again, the Inspectorate repeated the costly inefficiency of providing offices for persons who use them for only a few hours a week. While consultants should have dedicated offices, these should not be in the acute unit, but rather in their sector headquarters. The Inspectorate felt that the occupational therapy unit was generously spaced for the needs of short-stay patients and its garden area was extensive, with part of it only being overlooked by the towering stories above. The high-observation area was self-contained and the intention appeared to be to keep it locked and separate from the main adult units. It had its own dining and day areas and all of this had considerable implications for staffing. There were six single sleeping rooms.

The seclusion room, which was threatening and disturbing in its internal appearance was, together with much of the patient accommodation in the main adult area unsafe. The later-life psychiatry component included a new acute pre-senile assessment unit, the only one in the country, and a replacement day hospital of considerable size, culminating in a garden which was not overlooked like the general adult and occupational therapy units.

A steering committee set up to deal with the difficulties presented by this new unit had recommended modifications which, it was estimated, would cost approximately €0.5 million. However, no adequate solution had been offered for the problem of the internal overlooked garden. The Inspectorate felt that the high-observation area should be integrated into one of the general adult wards and the seclusion room made safe. As there had been only nine episodes of transfer of patients from Unit 9 to St. Brendan's Hospital in 2002, the need for a separate high-observation facility was not extensive and likely to be much less in the new unit than in the existing Unit 9.

The Inspectorate was informed that there were 47 unprotected exits at Unit 9, necessitating almost continuous use of special nursing, of which there were 12,484 hours involving 78 patients in 2002. The Inspectorate stressed how necessary and urgent it was to resolve the difficulties in this unit, not alone because the land on which Unit 9 stood had been sold but because the closing of St. Brendan's Hospital rested, in part, on the transfer of

the remaining admission facilities in that hospital, currently serving the two Area 6 sectors of Cabra and Finglas, to the new psychiatric unit.

The nursing unions which had identified and set out clearly the difficulties in the new unit had met with management under the umbrella of the Labour Relations Commission to try and resolve some of these difficulties. It had been management's intention to move the acute admission facilities in Unit 9 to the new unit as a first step, before moving the Cabra and Finglas admission patients from St. Brendan's Hospital. However, for reasons unclear to the Inspectorate, the nursing unions had refused their agreement to this staged movement and were insisting on the whole process being facilitated simultaneously. A meeting between management and unions to resolve this issue led to no further initiative, so that it was currently deadlocked.

The Northern Area Health Board had requested considerable additional revenue funding to employ additional staff for the new unit. This included nursing staff for the general adult unit, staff for the occupational therapy unit and staff for the two later-life components. It would seem highly unlikely in the present climate, even if these requests were justified, that they would be acceded to. It seemed prudent to the Inspectorate that the expansion of the occupational therapy department and the proposed recruitment of staff should be, at the very least, modified.

Planning permission had been acquired for the change of use in relation to the Techport premises in Blanchardstown; work would shortly start for the conversion and modification of that premises to serve as sector headquarters for the two Blanchardstown sectors and as an acute day hospital. The Inspectorate welcomed this and noted that no comparable development existed in the Finglas or Cabra sectors, neither of which had sector headquarters nor acute day hospitals. The former day centre in the unsatisfactory North Road premises had been closed and moved to new, if rather cramped surroundings on the Century Industrial Estate. A new replacement medium-support residence in Church Avenue, Blanchardstown had commenced operation on a partial basis, as had the medium-support residence at Claremont Lawns, Glasnevin. Two further and adjoining houses in a local housing estate, Castle Curragh had also been purchased, but not yet opened. The situation regarding the high-support and other facilities in the North Circular Road service remained unchanged from 2002. The use of Conolly Norman premises had not yet been rationalised and services for Area 7 (Mater Hospital) were still provided there. They should, as the Inspectorate advocated in 2002, be removed and accommodated within the Area 7 catchment area.

The sectors needed multi-disciplinary strengthening, in the extension of both physical and human resources. Moves were afoot to acquire a consultant-led rehabilitation service and some specialisation in the field of liaison psychiatry was also needed.

RECOMMENDATIONS

In view of the seriousness of the acute admission accommodation crisis and its many ramifications facing this service and its patients, the Inspectorate limited their recommendations to one — that of setting up an implementation group, including nurse union representation, to resolve the outstanding difficulties in relation to the new unit in an imaginative, creative and expeditious manner, in a spirit of partnership mindful always of patient welfare as the primary consideration.

ST. BRENDAN'S HOSPITAL — 2003 INSPECTION

INSPECTED ON 16 NOVEMBER, 2003

GENERAL DESCRIPTION OF THE SERVICE

The population of the catchment area was 56,512, and it was divided into two sectors as follows:—

Sector	Population
Cabra	22,456
Finglas	34,056

St. Brendan's Hospital provided acute in-patient care for the Cabra and Finglas sectors of the Area 7 service and also for Area 6. It also supplied an in-patient care service for the homeless of the area; additionally, it catered for the intensive care needs of the ERHA psychiatric services. Finally, there were some long-stay patients resident in the hospital and some further persons residing in community residences near the hospital.

IN-PATIENT CARE

In-patient care was provided with 140 beds in five male and four female units.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	16	11	5	—	32	22.4
3-12 Months	—	—	8	9	4	2	23	16.1
1-5 Years	—	—	18	17	4	1	40	27.9
> 5 Years	—	—	11	29	6	2	48	33.6
All Lengths of Stay	—	—	53	66	19	5	143	100
% of Total	—	—	37.0	46.2	13.3	3.5	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
1	99	3	8	6	1
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
4	9	1	11	—	143

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	48	30	78
Temporary	33	19	52
P.U.M.	1	—	1
Ward of Court	3	—	3
Total	85	49	134

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
590	7.4	185	31.4	86.1	13.9	629	9

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

No day facilities were provided at St. Brendan's Hosptial.

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
3	19	—	—	6	69

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
14.64	21	230	87.5	14

COST

The cost of the St. Brendan's service was €28 million in 2002.

GENERAL COMMENTS

St. Brendan's Hospital, which once accommodated 2,000 patients, catered for 134 on the day of this inspection. They were a heterogeneous group, which ranged across acute admission patients from the Cabra and Finglas sectors of the Area 6 service, to 40 special care patients, 12 homeless and a high proportion, in some cases the majority, of long-stay patients in all locations. The Inspectorate felt that none of these patients were being well served by the accommodation and services offered to them. This does not imply any criticism of the efforts of the staff of St. Brendan's Hospital to improve matters and who, despite innumerable difficulties had succeeded in closing a ward — 23A — and further reducing numbers in 2002.

The difficulties faced — and to some extent overcome, at an unknown psychological cost — were disillusioning and demoralising. These included disempowerment and recurrent industrial relation difficulties. In common with most professionals, attempting to deliver services in the administrative area of the ERHA, the senior clinicians in St. Brendan's Hospital found themselves increasingly remote from the decision making process in relation to major service organisational change. The complaint heard everywhere by the Inspectorate had been that service development had been thwarted by an increasingly bureaucratic style of management, which had alienated workers on the ground from change-making and advance. Central to the confusion and uncertainty in St. Brendan's Hospital was ignorance as to the plans for the future of the buildings and campus. On our visit in 2002, it appeared clear that the grounds and buildings were to be taken over by the Dublin Institute of Technology and, that a small part of the campus would be retained for mental health services to build a number of in-patient structures for rehabilitation and for intensive care. The Inspectorate had been told that a joint project team had been established for this purpose. It appeared that this team was no longer functioning. Some months ago, St. Brendan's Hospital senior management had made it known to the ERHA and the Northern Area Health Board that they could not, in all conscience, continue to admit acute patients to the hospital unless there was a considerable improvement in conditions. The Inspectorate was informed that a meeting took place between representatives of all three groups and monies were promised for the remedial work. However, nothing further had been heard of this. Meanwhile, patients continued to be admitted to and cared for in conditions that were unacceptable.

The acute admission problem was immediately remediable with the re-location of acute in-patient beds to James Connolly Memorial Hospital. As had been pointed out, the two admission units, 3A and 3B were largely occupied by long-stay patients, leaving only a small number of beds for admission. The new acute admission unit for the Area 6 service in James Connolly Memorial Hospital in Blanchardstown was ready for occupation. Unfortunately, there had been some design faults with the unit, which were now being addressed and could be finalised, allowing for the reception of patients. While the negotiations with the unions were proceeding, patients from the northern sectors of Area 6

were being admitted to totally unacceptable conditions in unit 2 in James Connolly Memorial Hospital, where there was inadequate heating and the roof leaked and patients from the Cabra and Finglas sectors were being admitted to the admission units, 3A and 3B in St. Brendan's Hospital, which were also most unsatisfactory.

The intensive care programme, which was being carried out with a high level of clinical sophistication in quite unsuitable premises, required a new 15-place purpose built unit, such as had been envisaged as being provided on the residual grounds of St. Brendan's Hospital and, on the assumption that there would be two similar units elsewhere in the Eastern Region. Many of the patients in the current units, as well as most of those in the admission units and in the Willows required community placements and intensive rehabilitation. For this, more accommodation was required in the community and a specialised rehabilitation unit and team for St. Brendan's Hospital. While a second consultant post in the psychiatry of the homeless had been created, the post had not been filled: it was clear that a reorientation towards an innovative, well-resourced service for the homeless was needed, building on the current provision, which while centralised in its community aspects, on the streets and working in close harmony with related agencies in this field, would be decentralised in its acute in-patient requirements.

The assessment unit and its functioning should be abandoned, as the Inspectorate cannot see what useful function it provided and particularly as the admissions from Cabra and Finglas would soon pass to the new unit at James Connolly Memorial Hospital. The Inspectorate understood that this was also management's view, but that the matter was being negotiated with the unions.

There were 82 involuntary admissions to St. Brendan's Hospital in 2002 compared to 116 involuntary admissions the previous year: 13 patients admitted as involuntary patients were re-graded to voluntary status, 14 patients admitted as voluntary patients were re-graded to involuntary during their hospital stay. There were no transfers from St. Brendan's Hospital under Section 208 of the Mental Treatment Act, 1945, to the Central Mental Hospital in 2002; 14 patients were transferred from St. Brendan's Hospital to other psychiatric in-patient services outside of the catchment area. Ten of those transfers were non-nationals transferred back to their country of origin. Of the 629 discharges from St. Brendan's Hospital, 55 took their own discharge against medical advice and procedures were in place to follow-up these patients at out-patient departments, if deemed clinically appropriate. There were nine deaths in St. Brendan's Hospital last year, eight from natural causes and one by suicide. During 2002, 12 patients became new long-stay, i.e. one year continuous hospitalisation and less than five years.

Ten patients were prescribed ECT at St. Brendan's Hospital during 2002, compared to 22 patients in 2001: all arrangements were satisfactory. The consent form and pre- and post-ECT nursing checklists were all completed satisfactorily: vital signs were recorded pre- and at regular intervals post-ECT. There was a record in the in-patient clinical notes of discussions held with patients on the nature of this procedure, which included discussions

on the risks, benefits attached to the procedure and a note that the patient fully understood these. Assessment of clinical outcome following each ECT treatment was also appropriately recorded. Guidelines on the administration of ECT were prominently displayed in the treatment area.

In 2002, there were 905 episodes of seclusion, involving 92 patients in St. Brendan's Hospital: this was a marked reduction from the 178 patients secluded in 2001. A seclusion register was maintained and 15-minute nursing observations were appropriately recorded. Whilst there was no legal requirement to record the 15-minute observation of patients placed in seclusion overnight, the Inspectorate considered this good practice and recommended that it be done. All seclusion authorisations made by junior doctors were countersigned by consultants. Access to the seclusion rooms was off the ward corridors and patients in a number of rooms had an unrestricted view of a clock from the seclusion facility. There was a revised and updated policy and procedure relating to seclusion. In addition to the seclusion policy, the hospital should have a written policy relating to 'time out' which was a behaviour modification technique without the use of a locked room.

In 2002, 28 patients assessed as posing a risk to themselves or others were placed on one-nurse to one-patient special nursing supervision; there were 736 episodes of special nursing supervision involving duty spans of 10 hours or more. The number of patients placed on special nursing supervision had doubled from the previous year. A special care plan should be developed for patients on special nursing supervision. One patient in the special care unit posed a significant risk of self injury: a statement of the degree of risk was recorded and measures to safely manage the patient were in place. This included the use of special nursing supervision. In addition, a restraining vest had been purchased for possible use under medical supervision, but this had not been used. There was a need for a clear written policy on the use of restraint, to include provision for the review of each incident of restraint.

Each unit within St. Brendan's Hospital had a statement of purpose and function that accurately described what the unit set out to do and the manner in which care was provided. There were no research projects governed by the Clinical Trials Act, 1987-1990 undertaken in St. Brendan's Hospital.

In 2002, there were 23 requests made for information under the Freedom of Information Act, 1997 and five complaints made to the local complaints manager; all appear to have been dealt with satisfactorily. There was adequate information on the complaints/dissatisfaction procedure available to patients at St. Brendan's Hospital. Notices were prominently displayed at every treatment location and information included in the St. Brendan's Hospital leaflet for patients and visitors. Information on patients' rights under the Mental Treatment Act, 1945 and amending legislation was prominently displayed at each treatment location; however, it was not clear if this information was brought to the attention of patients. A system should be developed to survey patients' views on service provision; this would be a valuable reference tool when evaluating treatments. A similar system should be put in place to survey the views of patient's families.

In 2002, there were 26 accidents to patients; 14 resulted in minor injury. There were 66 assaults on patients by other patients and 67 assaults on staff; none were deemed serious. The reporting system for accidents, incidents and assaults was satisfactory. Accidents, incidents and assaults were analysed by the management team, in order to identify areas of care and treatment which required monitoring and review.

As mentioned in the 2002 Report, each patient at Unit 3A and 3B of St. Brendan's Hospital should be allocated a primary nurse directly responsible for their care on a day-to-day basis, including responsibility for the documentation of the nursing care plans and the presentation of clinical aspects of the patient's condition at all multi-disciplinary review meetings.

There was a generic safety statement and site-specific safety statement dated November 2002. Whilst there was provision for staff to sign that they have read and understood the safety statement only a few staff had done so. A set of safe work practice standards produced by the Eastern Regional Health Authority Shared Services contained a compendium of information on a range of health and safety issues within the workplace was available for staff information and reference. Fire fighting equipment was in place at all clinical locations and the system for checking the equipment to ensure it worked effectively was satisfactory. All staff attended fire lectures on a rotational basis. Emergency medical equipment was situated at appropriate locations and checked regularly.

Since the previous inspection, the multi-disciplinary group had introduced a set of revised policy and procedure documentation. All of these would be reviewed again in the context of the re-location of acute services to James Connolly Memorial Hospital and the reorganisation of services remaining at St. Brendan's Hospital. There was provision for staff to sign that they had read, understood and would comply with the contents of these documents, but again, the extent of compliance was quite variable. Monitoring and audit procedures should be introduced so that there was a regular check on the efficacy of these policies. The policy and procedure relating to patients absent from the hospital without official leave should be revised and the name of the person with responsibility for ensuring the return of the patient clearly stated.

Wards within St. Brendan's Hospital had a written philosophy of nursing care. Nursing care plans were organised using the 'Oram' model; however, the standard of nursing documentation was variable. In some wards, there was a tendency to revert to nursing notes or ward progress reports rather than nursing care plans, while in other wards, the standard of nursing documentation using the nursing model was reasonably satisfactory. There was a need for greater correlation between the nursing interventions and the nursing entries made in the report and evaluation sheet of the care plans. Ideally, all entries and nursing records should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment. Care plans were reviewed weekly or more often if necessary. All entries in the nursing records were accurately dated; time of entry should be recorded using the 24-hour clock. There was an improvement in the overall standard of nurse record-keeping, but much work needed to be done in some areas to ensure uniformity. Staff wore identifying name badges indicating their designation within

the multi-disciplinary team. A system of informing patients of hospital charges should be introduced.

There was a written drugs policy and procedure dated November 2002, which was available in all clinical areas. Individual prescriptions examined were of a satisfactory standard: all were signed and dated individually; the discontinuation column had one date and one signature for each prescription and were within current date. On a number of cards examined the recording of drug allergies or drug sensitivities was not completed. If there were no known drug allergies or drug sensitivities, this should be recorded. Many files, especially in the admission unit, were rather bulky with storage of a considerable collection of loose clinical material within the file. With some larger files, it was difficult to locate some details due to haphazard filing; it was also difficult to determine between each in-patient episode. In some instances the signature of the professional staff making the entry in the record was not legible. Ideally, the person making the entry should print their name and sign and record and state their designation; this would facilitate easier identification of the staff member in the future.

The two community residences at Grangegorman Villas visited as part of this inspection required extensive refurbishment and redecoration. These houses, which were used as high-support community residences were overcrowded and could be more appropriately used as low- to medium-support accommodation. A service users' guide should be available outlining a brief description of the accommodation and service provided. There should be a programme of routine maintenance and renewal of the fabric and decoration of all community residences.

The Inspectorate was happy with the level and variety of patient activities in the special care unit activities centre, which included craftwork, current affairs discussions, social skills, relaxation therapy and less intensive forms of group therapy. This activity centre worked well and was an ideal outlet for patients residing in the four units. Patients in these units had access to fresh air via the substantial and secure garden areas which were reasonably well maintained; in one area a patient was facilitated in growing vegetables.

Three patients, two males and one female, randomly selected from the admission unit were interviewed to ascertain their views of the service provided; all were of voluntary status and had previous admissions. Two patients were pleased with the admission procedure at the hospital, were introduced to the professional team responsible for their care and knew the name of their consultant psychiatrist. They were also pleased with the frequency of consultations with their consultant psychiatrist. One patient was not satisfied with the courtesy and helpfulness of the staff. While he acknowledged that some of the nurses and staff were marvellous, he alleged that some were "less than helpful". One patient was not aware of a nursing care plan or whether he had a primary nurse responsible for his care. All patients had been informed about their psychological problems; their prescribed medication had been fully explained to them as has the effects and side effects of same. One patient was not aware of his rights under the mental treatment legislation nor was he aware of any complaints procedure being in place but he thought there was a

notice framed and hanging on the wall in the patient areas. He was not offered any information booklet on the hospital or unit. All patients complained about the quality of the food in St. Brendan's Hospital. While the patients were satisfied with the general cleanliness of the ward, all complained about the hygiene of the bathroom and toilet areas. Two patients were unhappy with the privacy in the shower area, as staff accessed the stores via the shower area. All patients were pleased with the activities offered in Unit 23A by Occupational Therapists. This was a new arrangement and patients found the various activities very helpful. When asked how they would like to see the services improved, all patients said they would like to have access to the new unit and, pending that, the kitchen should be modernised and greater privacy should be available in the shower room area.

RECOMMENDATIONS

It is recommended that:

1. Regular formal planning meetings be established between senior management of the ERHA, Northern Area Health Board and St. Brendan's Hospital to lift the demoralising obfuscation that hindered forward planning and management of the service being delivered at the hospital.
2. The new acute admission unit at James Connolly Memorial Hospital open without delay.
3. A purpose-built unit for intensive care be provided.
4. A rehabilitation unit and consultant-led rehabilitation team be established.
5. A comprehensively resourced and planned programme for psychiatry of the homeless to complement what already exists in this field be put in place.
6. The assessment unit be closed.
7. The community residences adjacent to the hospital be upgraded as a matter of urgency.

**ST VINCENT'S HOSPITAL, FAIRVIEW; PSYCHIATRIC UNIT, MATER
MISERICORDIAE HOSPITAL (AREA 7) — 2003 INSPECTION**

INSPECTED ON 9 DECEMBER, 2003

GENERAL DESCRIPTION OF THE SERVICE

The population of the catchment area was 138,000, and it was divided into five sectors as follows:—

Sector	Population
Ballymun	22,000
Marino	29,000
Mater Hospital	30,000
Millmount	31,000
North Strand	26,000

This service catered for the Area 7 mental health needs of Dublin North Central, through a limited range of community-based facilities and with in-patient beds at the free-standing St. Vincent's Hospital, Fairview and the Acute Psychiatric Unit, St. Aloysius, at the Mater Hospital. There was a specialised service for the elderly shared with Area 6 and a liaison /consultation service to the Mater Hospital. Overall, the services were administered by three sources, the board of the independent St. Vincent's Hospital, Fairview, and the Northern Area Health Board who administered the community services and on whose behalf St. Vincent's hospital operated and the Mater Hospital.

IN-PATIENT CARE

St. Vincent's Hospital, Fairview had 92 beds and the Acute Psychiatric Unit, Mater Misericordiae Hospital had 15 beds.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	13	8	4	4	30	49.2
3-12 Months	—	—	1	6	4	—	11	18.0
1-5 Years	—	—	2	6	2	2	12	19.7
> 5 Years	—	—	—	2	4	2	8	13.1
All Lengths of Stay	—	1	16	22	14	8	61	100
% of Total		1.6	26.2	36.1	23.0	13.1	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
3	35	—	14	—	2
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
—	—	—	6	1	61

Status of In-Patients on date of Inspection 2003 — ST. VINCENT'S HOSPITAL, FAIRVIEW

Status	Male	Female	Total
Voluntary	28	27	55
Temporary	7	14	21
P.U.M.	—	—	—
Ward of Court	1	1	2
Total	36	42	78

Status of In-Patients on date of Inspection 2003 — MATER MISERICORDIAE HOSPITAL

Status	Male	Female	Total
Voluntary	5	6	11
Temporary	1	1	2
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	6	7	13

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
881	6.4	90	10.2	84.2	15.8	670	6

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	50	1,091
Day Centres	4	185	1,051
Out-patient clinics	11	547*	9,600

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
4	32	2	14	2	32

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
21.45	38.64	205.73	69.27	17.45

COST

The cost of Area 7 Mental Health Service was €19.7million in 2002.

GENERAL COMMENTS

There was little new to report about this service since the visit in 2002. The community services had not expanded and the one day hospital, Crannóg, based at St. Vincent's Hospital, Fairview attempted to cater for all sectors. It was staffed clinically by a separate team, thus sacrificing continuity of care otherwise provided by the responsible sector professionals. The Inspectorate noted that 62/63 Eccles Street had been refurbished to serve as a sector headquarters for the Mater sector, which provided luxurious accommodation for staff; even students had entire offices to themselves. By contrast, patient usage of the premises was quite limited and there was no day hospital. None of the necessary repairs to existing community facilities, such as Tara House and the St. Laurence's Road premises had taken place because of funding inadequacies.

The acute in-patient accommodation provided in two separate locations was unsatisfactory. St. Vincent's Hospital, Fairview was free-standing and not based in a general hospital, as current policy dictated; the Mater unit was too small and too cramped to perform a satisfactory service function for the catchment area. In the Inspectorate's view, the appropriate solution would be a 30-bedded modern unit in the Mater Hospital serving the entire catchment area — it was worthy to note that the upgrading of the Mater Hospital did not contain any psychiatric component, although there would be access to the new out-patients department.

The lack of community sector-based facilities was reflected in the 1246 referrals to St. Louise's unit at St. Vincent's Hospital for assessment in 2002; these referrals would have been much more appropriately assessed in community settings. Ironically, none were referred to Crannóg. Both admission units, but particularly the Mater Hospital, were concerned at the large numbers of homeless patients who presented; this reflected the failure of the ERHA to devise a policy and put in place the structures of care for this increasingly growing problem. A liaison nurse had been recruited in an attempt to make an impression on this and other similar problems. The threatened requisition of places for children of the child psychiatric service in the Mater unit had not materialised.

There was a need for the rationalisation, including the community placement of patients in the old St. Vincent's building and, in this respect, the Inspectorate was encouraged to hear that the service hoped to recruit a rehabilitation team.

In both in-patient locations, case note structure and organisation had improved: reasonable coherent and extensive clinical information, such as intake assessment and programme construction, were available. There was still some way to go in completing the multi-disiplinarity of teams, although matters were better than elsewhere in this respect.

There were 27 temporary admissions to the Mater Hospital and 109 patients admitted on temporary certificates to St. Vincent's Hospital in 2002: seven patients were re-graded to

voluntary status during the course of their hospitalisation. Three patients admitted to the Mater Hospital and seven to St. Vincent's Hospital as voluntary patients were re-graded to involuntary status during the course of their hospital stay. Three patients admitted to St. Vincent's were wards of court. Two of the admissions to the psychiatric unit at the Mater Hospital were aged 16 years or under. Also in 2002, 23 patients had their involuntary admission orders extended. Statistical data relating to the number of liaison consultations by consultant psychiatrists to the general wards at the Mater Hospital and to the A&E Department were not available at the time of inspection.

Of the 670 discharges from St. Vincent's Hospital, Fairview, nine patients took their own discharge against medical advice; appropriate procedures were in place to follow up these patients if deemed necessary. There were six deaths in St. Vincent's Hospital in 2002; all from natural causes. In 2002, 13 patients became new long-stay patients, 12 at St. Vincent's Hospital and one at the Mater Hospital and three of the St. Vincent's patients were aged 65 years or over.

The Department of Later-life Psychiatry provided services for the Area 6 and Area 7 catchment areas and there were 168 patients on the register at the end of the year. There were 369 first referrals in 2002. Six acute assessment beds were provided at St. Vincent's Hospital, Fairview and there were 38 admissions to this unit in 2002. The day hospitals for the later-life service were located at James Connolly Memorial Hospital and at Eccles Street adjacent to the Mater Hospital. There were 614 attendances at Eccles Street in 2002 and 65 patients were referred to this hospital during the course of the year.

There were 20 episodes of seclusion involving seven patients at the Mater Hospital. In addition, there were 19 episodes of one-to-one special nursing supervision at the Mater Hospital Unit involving 11 patients. There were 41 episodes of seclusion at St. Vincent's Hospital involving 17 patients, a small reduction in episodes and patients from the previous year. While facilities at St. Vincent's Hospital were structurally appropriate there were some problems; appropriate room furnishings should be provided for the safe room. Access through the room was off the ward corridor and there was adequate privacy for patients while in seclusion. A seclusion register was maintained and nursing observations appropriately documented. Patients in seclusion had an appropriate care plan, which included information of events prior to each seclusion episode noting the actual behaviour of the patient and intervention used prior to the seclusion episode. All nursing and medical documentation in relation to seclusion was appropriately cross-referenced to the special seclusion register and a multi-disciplinary review was completed and documented for each episode of seclusion.

In 2002, 15 patients at St. Vincent's Hospital, Fairview and ten patients at the Mater Hospital were prescribed ECT; in addition, two patients from St. Ita's Hospital had ECT treatment at St. Vincent's Hospital due to the closure of their facilities. Guidelines for the administration of ECT were prominently displayed in the treatment areas and there was a named consultant psychiatrist responsible for the treatment. Appropriate medical emergency equipment was in place and was tested before commencement of the procedure. The consent form in use was satisfactory and the pre-and post-ECT nursing checklist

included records of patient's vital signs. Records of the physical examination prior to treatment were appropriately documented in the clinical notes as was the assessment of the clinical outcome following each treatment. St. Vincent's Hospital had a patient information leaflet on ECT.

The reporting mechanisms relating to accidents, incidents and assaults in St. Vincent's Hospital, Fairview were of a very high standard. There were 153 recorded accidents to patients and 10 recorded accidents to staff in 2002; none were deemed serious. There were 21 recorded assaults on patients by other patients and 22 recorded assaults on staff; again, none were deemed serious.

The standard of nursing documentation at both locations was satisfactory. Comprehensive nursing care plans using the 'Roy' model of nursing at St. Vincent's Hospital and the 'Tidal' model of nursing at the Mater Hospital were recorded. Each nursing care plan specified the details of nursing interventions for each problem or self care need identified. Nursing documentation contained relevant information relating to the observation of patients and changes in the patient's condition as they progressed with their treatment while hospitalised. A nursing discharge summary was recorded for each patient and contained a note relating to patient's usual pattern of sleep and how they settled into the ward following their first day of hospitalisation. All entries and nursing documentation were accurately dated and the biographical data sheet for admission appropriately recorded. There was a system within this catchment area whereby management regularly reviewed different aspects of service provision in order to provide feedback to staff about performance. There was a good standard of clinical audit within this service with a process for dissemination of audit results; this was coordinated by a multi-disciplinary team. Audits were conducted via a predetermined list of questions about the quality of care as applied to the experiences of the patients, the perceptions of staff and a scrutiny of the records of care. This service in this regard set examples that many other services in the country might follow. A new pilot nursing assessment framework was under active consideration, involving patients and staff of the St. Louise's admission unit. The revised documentation required the active participation of the patient in their own care and treatment. Recommendations had been made for the full implementation of this pilot project and it was hoped that this would be introduced shortly after our inspection.

Information notices on patients' rights under the Mental Treatment Act, 1945 were prominently displayed at all in-patient locations. However, there was no system in place to verify whether this information had been brought to the attention of patients. Information on the local complaints procedure was contained in the hospital leaflets which were given to patients on admission; information on hospital charges should also be included.

A three-year strategic plan should be produced for this service. In tandem with this, an annual report should be produced highlighting the strengths and weaknesses of service provision and linked to service projections and targets. In addition to the clinical audit and risk assessment initiatives which were of a high standard, patient and family users' satisfaction surveys should be conducted to inform this process.

The out-patient facilities at the Marino clinic were not adequate; there were difficulties relating to privacy and confidentiality. An appointment system was in operation, resulting in a waiting list for out-patient consultations. The waiting list at the Ballymun clinic was approximately five weeks, North Strand; three weeks, Marino; five weeks, and the Mater Hospital, six months. All patients on the waiting list were prioritised by a consultant psychiatrist and were seen according to need. In emergencies, patients were seen at the acute wards as a priority.

Clinical policies, procedures and guidelines in this service were of a high standard and were under review at the time of our visit. Fire safety precautions and health and safety statements, both general and site specific, were in place. Records should be kept of safety audits and outcomes in each local area. The physical facilities at Tara House and at 87 St. Laurence's Road remained unsatisfactory. Lindsay House, which was due to open as a medium-support hostel remained empty, due to the staff recruitment embargo.

Three patients, randomly selected, were interviewed to assess their views of psychiatric services provided: two male and one female. One patient was of voluntary status, one was temporary and the third patient was unsure of his status. Patients were asked about issues such as quality of information provided and aspects of their care to highlight areas where the local service needed to make improvements. All of the patients interviewed were satisfied with the admission process. They were pleased with the courtesy and helpfulness of staff, were introduced to the professional team responsible for their care, knew the name of their consultant psychiatrist and had adequate access to them whilst hospitalised. All patients were aware of the primary nursing system; however, one patient was unsure what this meant. Patients reported being satisfied with the information given to them about prescribed medication and its long- and short-term effects. While two patients were happy with aspects of privacy and dignity relating to their care, one patient disliked the multi-disciplinary approach and would prefer one-to-one consultations. Patients were generally satisfied with the quality and quantity of food provided. However, one patient was a vegetarian and felt that the catering department was not geared to providing suitable meals. Patients felt that the standard of hygiene and cleanliness of the ward was good. However, all the patients complained about the hygiene of the bathrooms and toilet area. On the day of inspection the toilets were not in working order.

While all patients reported being satisfied with the occupational therapy activities and relaxation activities, one said she would appreciate more physical activities.

When asked how the services could be improved, one patient said he would appreciate more organised trips. Another patient said she would like more space: she would prefer a single room rather than the four-bedded room she occupied. This patient also disliked the constant locking and unlocking of doors.

RECOMMENDATIONS

It was recommended that:

1. Community services and facilities for this catchment be extensively strengthened.
2. Existing facilities, particularly, Tara House and St. Laurence's Road be upgraded.

3. Serious thought be given to the deployment of the 62/63 Eccles St. premises to best patient advantage.
4. A specialised rehabilitation team be recruited for the service.
5. Lindsey House be opened as a community residence.

DUBLIN NORTH-EAST MENTAL HEALTH SERVICE (AREA 8)

ST. ITA'S HOSPITAL PORTRANE — 2003 INSPECTION

INSPECTED ON 3 DECEMBER, 2003

GENERAL DESCRIPTION OF THE SERVICE

The population of the catchment area was 202,157, and it was divided into five sectors as follows:—

Sector	Population
Coolock/Darndale	25,829
Kilbarrack East	40,062
Kilbarrack West	31,946
Swords/Balbriggan	79,699
Killester	24,621

The Area 8 service provided for the sectors of its catchment through a variety of community-based services of varying extent and quality, for general adult, later life, rehabilitation and general hospital liaison specialties and through in-patient care at St. Ita's Hospital, Portrane. Liaison consultations were provided at Beaumont Hospital and outreach community programmes were in place at one or two of the sectors.

IN-PATIENT CARE

There were 204 beds in four male, four female and three integrated wards in St. Ita's Hospital.

Age and Length of Stay of all Patients on 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	17	12	8	6	44	23.0
3-12 Months	—	2	2	7	6	5	22	11.5
1-5 Years	—	—	6	8	20	16	50	26.2
> 5 Years	—	—	2	15	28	30	75	39.3
All Lengths of Stay	—	3	27	42	62	57	191	100
% of Total		1.6	14.1	22.0	32.5	29.8	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
44	102	13	15	4	1
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
1	7	—	4	—	191

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	53	50	103
Temporary	10	4	14
P.U.M.	—	—	—
Ward of Court	3	3	6
Total	66	57	123

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
764	3.8	247	32.3	89.9	10.1	695	27

*Per 1,000 population

COMMUNITY FACILITIES**DAY FACILITIES**

	Number	No. of Places	No. of persons attending
Day Hospitals	3	85	258
Day Centres	2	55	98
Out-patient clinics	19	1,245*	2,837

*No. of out-patient clinics held in 2001

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
1	8	4	30	3	22

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
30.5	31.5	303.5	48	8

Cost

The cost of St. Ita's Mental Health Service was €23.7 million in 2002.

GENERAL COMMENTS

The community-based components of the Area 8 services were in the process of development, with new outreach initiatives in Swords and Balbriggan. There was a realisation that a great deal more needed to be provided by way of mental health centres, day hospitals and community residences. However, a new community residence, Inch, at Balbriggan, which accommodated 10 residents had opened in 2002. Three other recently-acquired houses in Donabate and Rush should soon be opened to take, *inter alia*, the patients currently in Woodview Lodge, which should be closed and renovated. The medium-support residence at Lispopple, Swords had 10 residents, an increase from five the previous year. The community infrastructural deficiencies were acknowledged in a recently produced plan for community service development in the area. As well as catering for general adult psychiatry, specialties were now being added, particularly in the field of later-life psychiatry and rehabilitation psychiatry, with the setting up of teams, which required multi-disciplinary strengthening, in these two specialties. Both required improved physical resources; Woodview House was not a satisfactory base for the rehabilitation service nor was Unit 8 appropriate for acute assessment purposes for the later-life service. However, this latter problem would be solved by the opening of the Beaumont unit with its complement of six acute assessment beds for this service. The 15-year plan of replacing the admission wards in St. Ita's Hospital with a psychiatric unit at Beaumont Hospital seemed to be progressing, with the completion of the planning and design elements of the task and the upcoming planning application. This was essential because of the unacceptable nature of the current admission wards in St. Ita's Hospital.

The ERHA had decided that some, or most, of the campus of St. Ita's Hospital should be disposed of for housing purposes, subject to the necessary planning permission. Should this happen, it would be appropriate that some of the accruing capital would be invested in community infrastructure for the service. In the meantime, considerable progress had been made in reducing the number of long-stay patients in the hospital. During 2002, these had reduced by 50, from 185 to 135, largely by the closure of the Reilly's Hill complex and the transfer of the residents to community-based settings and to nursing homes. That further progress along these lines was possible was exemplified by the fact that most patients in wards 1A and 1B were quite elderly. Indeed, at the end of 2002 over 60% of residents were over 65-years of age, but this proportion had been reduced by the Reilly's Hill closure.

In 2002, 73 patients, 34 male and 39 female were admitted to St. Ita's Hospital on temporary detention orders: three patients admitted were wards of court and one patient was admitted by court order. Seven patients admitted as involuntary patients were re-graded to voluntary status and 13 patients admitted as voluntary patients were re-graded to involuntary status whilst hospitalised. Also in 2002, there were 54 extensions of involuntary admission orders at St. Ita's Hospital. Statistical information relating to the number of patients lodged overnight but not formally admitted was not available at the time of our

visit but this number had significantly reduced in recent years. Of the 695 discharges from St. Ita's Hospital in 2002, 71 patients took their own discharge against medical advice and follow-up procedures were in place if deemed clinically appropriate. There were 27 deaths at St. Ita's Hospital last year all from natural causes.

Twenty patients became new long-stay patients; 15 of those were aged 65 years or over. This figure was high by national standards and indicated a lack of facilities for older persons within the community. It was hoped that the establishment of the later-life service and its integration into the community structures would have impacted significantly on this figure for 2003. There were 222 referrals to this service between July and December 2002. The service used Unit 8 at St. Ita's for assessment purposes and there were two admissions to the unit up to the end of 2002. Long-stay facilities for the service were located at St. Ita's Hospital. The community nurses attached to the Department of Later-Life Psychiatry had 46 referrals up to the end of 2002 and participated in 257 home visits. There was no day centre or day hospital for this service. Domiciliary assessments were provided by the consultant psychiatrists and there were 123 domiciliary assessments by the consultants, four by the registrar and 27 by social workers from the commencement of service in July to the end of December 2002. A total of 105 patients attended the out-patient department during 2002, which was located at Beaumont Hospital and St. Ita's Hospital.

A liaison/consultation service in psychiatry was operated at Beaumont Hospital by a consultant. There were 559 liaison consultations in 2002, resulting in 149 admissions to St. Ita's Hospital, 243 referrals to the out-patient department at St. Ita's Hospital, 40 medical admissions to Beaumont Hospital, 133 referrals to General Practitioners, 13 referrals to the later-life services and 21 referrals to the substance abuse services. There was also a professorial appointment, with sessional obligations to the service, working in Beaumont Hospital. The Inspectorate was unclear how the service commitments of this post to the service were being discharged.

There was one formal complaint made to the local complaints manager and ten requests for information under the Freedom of Information Act and all appear to have been dealt with satisfactorily. There was one research project governed by the Clinical Trials Act 1987-1990 undertaken in the St. Ita's service. In 2002, 78 accidents to patients and 16 accidents to staff were recorded: 42 of the patient accidents resulted in minor injury and six were deemed serious. There were 35 assaults on patients by other patients; none were deemed serious. Of the 44 assaults on staff, 16 resulted in minor injury and nine were deemed serious. The number of accidents and assaults appears to have increased substantially from the previous year. This may have resulted from a more robust scrutiny of reporting, tracking and trending of all adverse accidents and assaults. The most important aspect of any reporting system was the willingness of staff to report accidents, mistakes and incidents immediately they occurred. This seems to be the case at St. Ita's Hospital. The Inspectorate was pleased to note that all incidents reported were coded for severity of injury.

During 2002, there were 81 episodes of seclusion involving 32 patients, which was a marked decrease from 62 patients and 108 episodes in 2001. The Inspectorate noted that

the unsatisfactory seclusion facilities at Willowbrook had closed and the room was to be converted to a patient's bedroom. The practice of transferring patients from the admission unit to Willowbrook had also ceased following our suggestions of last year. There was adequate privacy for patients in the seclusion facilities and the safe rooms of both admission units and nursing observation were appropriate. A seclusion register was appropriately maintained and nursing observations documented as per the requirements of the Mental Treatment Act, 1945. All of the nursing and medical documentation in relation to each seclusion episode was cross referenced to the special seclusion register. The service should consider documenting the patient's response to each seclusion episode during and after each event. Seclusion authorisations were made by junior doctors but countersigned for the most part by consultants. Patients, whilst in seclusion, should have an unrestricted view of a clock from the seclusion room.

Five patients were placed on one- nurse to one- patient special nursing supervision during 2002 and there were 146 episodes of special nursing involving duty spans of 10 hours or more.

During 2002, 33 patients were prescribed ECT at St. Ita's Hospital. There was a dedicated ECT treatment suite with treatment and recovery rooms in the admission complex. The treatment area had been out of commission for six weeks prior to our inspection as all policies and procedures relating to this treatment were under review. Patients requiring ECT during that period were brought to St. Vincent's Hospital, Fairview. Guidelines for the administration of ECT were prominently displayed in the treatment area. The consent form in use for ECT was satisfactory. A record should be made in the clinical notes that the patient fully understood the nature of the procedure. There was a pre- and post- ECT nursing checklist which was completed satisfactorily and vital signs were recorded pre- and at regular intervals post-ECT. Information leaflets, which included information about the risks of ECT and the availability of alternative treatments, were required to enable patients make an informed decision regarding the appropriateness of this treatment.

The policy for the ordering, prescribing, storing and administration of prescribed medicinal products was under review. Overall, the standard was quite variable throughout the service: not every prescription was signed and dated. Written instructions for the use of prescription cards were required. The drug administration card did not have provision for the nurse's signature in full. However, a signature bank with samples of the nurse's signature and initials was maintained in the admission complex. Discontinued drugs were not always signed off using the discontinuation column and where they were, some of the signatures were not legible: there were serious risk factors associated with this. A number of prescription cards examined should be rewritten, as the number of discontinued prescriptions were far greater in number than current prescriptions. There was provision for the recording of drug allergy and drug sensitivity so that information was rapidly available to staff and this had been completed satisfactorily in all cards examined.

The quality and choice of food was satisfactory. Some improvements were required in food preparation areas of wards in the long-stay area. The physical environment of the

dining areas was generally satisfactory but the admission unit dining room could be overcrowded if the unit operated at full occupancy. A printed menu should be available for patients' information.

The Board safety statement was dated April 2002, but there was no site-specific safety statement available at local units. A safety audit had been completed on 19/10/2000 and most of the risks were of the low- to medium-category. The safety audit identified a hazard associated with the collection of dust in the kitchen area over an extractor fan. The situation remained the same at the time of inspection, there was no evidence that the matter had been attended to. In relation to risk assessment, there was a detailed policy setting out actions to be taken by staff when patients absent themselves without leave from the service. There were also guidelines for patients regarding drug and alcohol use. There was a need to develop a risk management strategy to identify risks or hazards. A new committee had been established to review the current policy and the management of violence. The Inspectorate noted that this committee consisted mainly of nursing staff and suggested that the membership should be increased to include representatives from other disciplines within the multi-disciplinary team.

Policies, procedures and guidelines had been reviewed in 2002 and revised policies introduced to all staff. The content of the policies was detailed and unambiguous with responsibilities clearly defined. A smoking policy should be introduced with smoking confined to designated areas only. The issuing of tobacco products from ward stores to patients should be discontinued and a more appropriate system of enabling patients purchase their own tobacco products if required introduced. Patients had limited access to the shop in the hospital grounds but it was Board policy that the shop did not stock cigarettes. Because of the locked doors, patients in the admission units had difficulties in accessing this shop. They also had difficulties in accessing fresh air as this was dependant on sufficient nursing staff to supervise external activities.

While patients were informed of diagnosis and treatment plans, notes on these discussions should be clearly recorded in the clinical files. Similarly, while information on patients' rights was prominently displayed in the admission areas it was not clear if this information was brought to the attention of patients. The patient information leaflet was under review and a revised and more comprehensive booklet was in draft form. In addition to the information booklet, a discharge booklet was in draft form, which gave information and advice to patients on discharge from hospital; who to contact in an emergency, discharge medication and the names and telephone numbers of local support groups.

Each newly-admitted patient had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and clear immediate management plan appropriately documented in their clinical file. There was provision for the recording of the patient's name on each continuation page but this was not always recorded. Time of assessment should be recorded in addition to the date.

The 'Oram' human needs model of nursing was the preferred nursing model in this service. Care plans were reviewed as necessary and appropriate training for staff on the use of the

care planning system was provided. The nursing records examined contained relevant information relating to the nursing observation of the patient and changes in the patient's condition and progress with nursing and medical interventions. All entries in nursing documentation should contain the signature in full with block lettering alongside the signature of the first entry and the status of the nurse. Whilst all entries were accurately dated, time of entry should be recorded using the 24-hour clock. The patient's primary nurse or allocated nurse should be entered in the nursing record. Ideally the nursing record should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment. Similarly, evaluations of nursing care plans should include patients' views about their progress.

Training needs analysis, using the 'Quasar' quality assurance audit tool, was conducted since the previous inspection to assist the service in planning, prioritising and co-ordinating study days, workshops and appropriate training courses for staff. The Inspectorate welcomed this audit and recommended that funding should be allocated to ensure its ongoing implementation.

Three patients, two male and one female, randomly selected, were interviewed at the admission units to assess their opinion of the psychiatric services provided: all had previous admissions. The first patient interviewed was pleased with the admitting procedure at the unit and was very satisfied with the courtesy and helpfulness of the staff. As he was only four days on the unit he could not recall the name of his consultant psychiatrist but was pleased with the consultation he had with her. The potential side effects of his prescribed medication had been fully explained to him. He was a diabetic and appreciated that a nursing care plan had been arranged for him and that there was a primary nurse responsible for his care. At the time of the visit, the complaints procedure and patient's rights under the mental treatment legislation had not been explained to him. He was very pleased with the quality of food provided and also with its presentation. He noted a vast improvement in the décor of the unit since he was last an inpatient, in particular, the standards of hygiene and cleanliness in the toilets and bathroom. He was also pleased with the various activities offered by the occupational therapy department in the adjoining unit.

The second patient interviewed was a detained temporary patient suffering from an enduring mental illness who found it difficult to sustain a coherent conversation. He could not recall the names of his consultant or primary care nurse. He said his diagnosis, treatment, or side effects of medication were never explained to him. Neither was he offered any information booklet on the hospital unit. He was, however, pleased with the privacy afforded him. He felt that the hygiene and cleanliness of the unit varied from day to day. He complained that his personal belongings in his locker were repeatedly pilfered. When asked how he would like to see the services improved he indicated that he would like to receive more precise instructions from doctors and nurses on his medications, day passes, etc. and that better care should be taken of patients' personal belongings.

The third patient interviewed was a temporary patient and had spent seven months in the unit. At the time of the visit, she had just completed a six week period of one-to-one special nursing following a self harm attempt. On admission, she was introduced to her

therapeutic team: she was pleased with her consultant psychiatrist with whom she had consultations three times weekly; she was also satisfied with the nurses and the social worker. However, she had not been referred to a psychologist. The effects and potential side effects of her prescribed medications had been fully explained to her and she was aware of her rights under mental treatment legislation. She did not like the food and had tea and toast only. She was not happy with the privacy provided as each time she pulled the bed curtains around her bed the nurses pulled them back. However, this was for observation purposes in view of her history. She would like to attend occupational therapy activities in the adjoining unit but was precluded from doing so because she was still in her night attire for safety reasons. She alleged that illegal drugs were sometimes used on the ward. When asked what improvements she would like to see in the services, she says she would like more integration of male and female patients.

RECOMMENDATIONS

The recommendations appropriate for this service were well known to the service providers and were being pursued by management. However, at risk of being repetitive we enunciate the two major ones again.

1. The Beaumont acute unit be built and opened as quickly as possible.
2. The proceeds of the proposed sale of St. Ita's Hospital land or some of it be deployed in the extension and strengthening of the physical and multi-disciplinary human resources of the community services.

ST. JOSEPH'S INTELLECTUAL DISABILITY SERVICE, ST. ITA'S HOSPITAL, PORTRANE — 2003 INSPECTION

INSPECTED ON 6 NOVEMBER, 2003

St. Joseph's Service provided a general in-patient and community service for intellectual disability for North Dublin City and County, with particular emphasis on psychiatric disorder; the general services were co-ordinated with those of voluntary agencies in a partnership arrangement.

IN-PATIENT CARE

In-Patient care was provided with 253 beds in sixteen nursing units.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	—	—	—	—	—	—
3-12 Months	—	1	1	—	—	—	2	0.9
1-5 Years	—	—	11	6	—	1	18	7.8
> 5 Years	—	—	70	78	49	14	211	91.3
All Lengths of Stay	—	1	82	84	49	15	231	100
% of Total	—	0.4	35.5	36.4	21.2	6.5	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	2	—	—	—	—
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
—	—	—	229	—	231

Status of In-Patients on the date of Inspection 2003

Status	Male	Female	Total
Voluntary	138	74	212
Temporary	2	—	2
P.U.M.	—	—	—
Ward of Court	7	9	16
Total	147	83	230

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate	No.	% of all	Voluntary	non-voluntary		
28	N.A.	12	42.8	100	—	37	11

COMMUNITY FACILITIES**Day Facilities**

	Number	No. of Places	No. of persons attending
Day Hospitals	—	—	—
Day Centres	1	11	11
Out-patient clinics	4	109*	96

*No. of out-patient clinics held in 2002

COMMUNITY RESIDENCES

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
1	5	4	27	3	22

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
4	—	309	249.5	—

COST

The cost of the St. Joseph's Intellectual Disability Service was €26 million in 2002.

GENERAL COMMENTS

This service was administered by the same management as the St. Ita's Mental Health Service. The Inspectorate had pointed out in many previous reports that this was unsatisfactory and that it would be beneficial to both services if their administration were separate. This was even more important now that there were four personnel vacancies in the administrative complement at St. Ita's Hospital.

This service was operated in conjunction with a number of voluntary agencies, which augmented the 204 places at St. Ita's Hospital and the 80 community residential places also provided by St. Ita's, with a number of residential and day services. St. Ita's in-patient service provided for "dual diagnoses" patients which indicated persons with intellectual disability and co-morbid mental illness and it was estimated that about 40% of St. Ita's patients had significant mental illness. The Inspectorate was informed that there was an amicable, mutually supportive and growing partnership arrangement between statutory and voluntary agencies providing services to the Intellectually Disabled within the catchment area.

It was clear to the Inspectorate that sectorisation of the large catchment area was essential and that the voluntary agencies should enter into this arrangement in a coherent geographic sense. It was also essential that each sector — and there should be a minimum of three or four of these coterminous with the general psychiatric catchment areas — should be staffed by a consultant-led multi-disciplinary team. The existing situation was that St. Ita's Hospital clinical professionals consisted of two consultant psychiatrists and 306 nurses and care staff, with 46 vacancies. There were no social workers, psychologists, occupational therapists or physiotherapists, because recruitment to these posts had failed. As things stood, the service was incapable of providing sophisticated responses because of these deficits. If a satisfactory configuration was to come about, it was essential that community-based activity be provided by these multi-disciplinary teams, in particular, for the mental health needs of the intellectually disabled of the sectors. This might require some re-orientation of teams, incorporating professionals from the voluntary sector. There should also be a bed allocation available to the intellectually disabled service of the North City and County sectors, in the appropriate acute psychiatric units or admissions unit of the relevant sectors for the treatment of acute mental illness in such patients. Furthermore, if this service was to be comprehensive, it should also embody liaison and forensic components.

The Clonmethan unit, which opened in 2002, had been highly satisfactory and had led to the reduction of in-patient numbers at St. Ita's Hospital. It was proposed to replicate and extend this type of provision. The first major initiative in this direction had been the proposal to build a 60-bedded complex at St. Ita's to replace some of the existing accommodation on the campus. This was welcomed by the Inspectorate, although it was felt that, like Clonmethan, it would be much more satisfactory if it was community-based

rather than at St. Ita's. However, it now seemed that this initiative was compromised on budgetary grounds. It was proposed however, to acquire six community-based houses, taking approximately four patients each; two of these had been, or were about to be purchased at Beaverstown, Donabate.

Some of the existing accommodation in St. Ita's Hospital was in need of upgrading, such as St. Joseph's. The Inspectorate was pleased to learn that €500,000 had been set aside for this purpose.

There were 28 admissions, 12 of whom were first time admissions to the St. Joseph's intellectual disability service in 2002: all were admitted on voluntary certificates and 65% of these patients had a dual diagnosis of intellectual disability and mental illness. In 2002, 37 patients were discharged from the St. Joseph's hospital service; one patient took discharge against medical advice. There were 11 deaths at St. Joseph's in 2002; all from natural causes. The service had responsibility for one low-, four medium- and three high-support community residences located in North County Dublin which accommodated 40 patients. There were seven admissions to these residences in 2002. A further 30 patients were accommodated in the Clonmethan residential complex at Oldtown. In addition to the activity centres on the campus, 11 patients had access to a day centre at Lusk in County Dublin which was staffed by two nurses and two care staff. The service had some association with partner services at the Daughters of Charity, St. Michael's House, Gheel autism service, L'Arche, St. Mary's, Baldoyle, Prosper, Fingal and the Estuary Centre. Through negotiation with the partner services, additional funding of €480,000 was provided for emergency placements. There were 28 patients on a priority waiting list in North County Dublin at the end of 2002.

As in previous reports, the Inspectorate wished to acknowledge the active involvement and participation of the voluntary association known as "The Parents and Friends of St. Joseph's". Members of the Association visited formally on a periodic basis and had unlimited access to all areas of St. Joseph's Hospital and all community residential areas. Representatives of the Association met with administrative, nursing and medical staff in order to air grievances and make recommendations relating to the care of residents. The Association, over the years, had made generous contributions from their funds towards social programmes for patients. In 2002 a once-off payment of €96,000 towards the provision of equipment was provided by the Department of Health and Children, through the Association. St Vincent de Paul, through the parents and friends, made a donation of €10,000 for the purchase of specialised educational equipment for the Montessori school located on campus.

The St. Joseph's service was participating in a pilot scheme, under the auspices of the National Disability Authority, reviewing and setting standards of care. This scheme had commenced with interviews of patients' relatives, service users and staff. External evaluation was to be conducted and a final report was due in 2004. In July 2003, a review of service provision at the residential and day service of the newly-established Clonmethan Lodge, Oldtown, County Dublin had commenced. Residents had re-located from the St. Joseph's service to these purpose-built facilities. A key system of any quality assurance

programme was a system whereby management regularly reviewed aspects of service provision and provided feedback to staff about their performance and the performance of the unit. The Inspectorate welcomed the review of service provision at Clonmethan and was anxious to receive a copy of the final report.

The role of the care assistant had been extended into sign language training, aromatherapy and recreational activities and it was hoped to introduce some level of formal training for this grade which had made its own unique contribution in partnership with the nursing and medical staff: 212 of the 237 allied staff were care assistants who worked across day, residential and community services. The staff of this service, both nursing and care staff, had adopted a very flexible approach to ensure patient care was maintained at a satisfactory level, in spite of the staff ceiling of December 2002, which had proved a major challenge for this service. There were approximately 23 nurses rostered on overtime on a daily basis to fill existing gaps in service provision. In view of the fact that it was likely to prove difficult to recruit qualified nurses in the future the logic of not recruiting when nurses were available and paying 23 nurses overtime on a daily basis must be questioned.

As mentioned in a previous inspection, cigarettes and tobacco products continued to be issued to patients from the hospital stores. While this was traditional in the old mental hospitals the Inspectorate had recommended that this practice be discontinued. Patients, if they wish to smoke should be given some monetary allowance and allowed purchase tobacco products from that allowance. It was noted that the hospital shop ceased to stock tobacco products a number of years ago, as part of a health promotion campaign. While this policy was supported by the Inspectorate, some special arrangement should be made for the more dependant patients of St. Joseph's Hospital who smoke. Programmes should be put in place to help patients give up smoking altogether, or at least reduce their dependence on tobacco products.

There were no research projects governed by the Clinical Trials Act, 1987-1990 undertaken in the St. Joseph's service. There were no complaints made to the local complaints appeals manager during the year. The four requests made under the Freedom of Information Act, 1997 were dealt with satisfactorily. Of the 77 accidents to patients, 59 resulted in minor injury and 11 were deemed serious. There were 48 assaults on patients by other patients, 26 resulting in minor injury but none were deemed serious. Of the 61 assaults on staff none were deemed serious.

There was a generic safety statement available at each local area. A site-specific safety statement and records of safety audits should be retained in each clinical setting. All senior personnel should be included in the local safety statement with a clear description of their responsibility: this should be reviewed by the local health and safety committee. The service should also consider developing a local risk management strategy. This will require regular reviews of accidents, incidents and assaults by date, time, location and cause.

There were 138 episodes of seclusion in the St. Joseph's service in 2002, involving 19 patients. There was a written seclusion policy and procedure and an appropriate seclusion register was maintained: 15-minute nursing observations of patients while in seclusion

were appropriately recorded. Seclusion authorisations were made by junior doctors. Nursing and medical documentation in relation to seclusion episodes were cross-referenced to the special seclusion register. Two patients were placed on one-nurse to one-patient special nursing supervision in 2002 and there were 382 episodes of special nursing involving duty spans of 10-hours or more.

A new nurse care planning record adopted from the 'Oram' human needs model had been introduced. Records comprised historical and personal data assessment details, plan intervention section and nursing notes. Some of the sections were well completed. However, the section on the health profile on a number of notes was not completed. While all entries were signed and dated, the signature in full should be used and the designation of the nurse making the entry clearly recorded. While there was provision for the recording of drug sensitivities and drug allergies, this was not always recorded. If there were no known drug allergies or drug sensitivities this should be stated, otherwise it might be viewed that an assessment of such was overlooked.

RECOMMENDATIONS

It was recommended that:

1. The St. Joseph's Intellectual Disability service be administered separately from the Adult Mental Health Services in St. Ita's Hospital.
2. The service be sectorised and integrated into the Intellectual Disability Service within the ERHA.
3. Each sector be coterminous with the catchment area of the Adult Mental Health Service and staffed by a multi-disciplinary team headed by a consultant psychiatrist.
4. Physiotherapy services be introduced at the hospital in areas of greatest need.
5. Most of the existing wards at the St. Joseph's complex be de-designated.
6. The proposal to build a 60-bedded complex (similar to the Clonmethan unit in Oldtown) to replace the existing accommodation at St. Joseph's Hospital proceed, preferably in projects of 30-bedded, community-based accommodation rather than on the campus of St. Ita's Hospital.
7. Cigarettes and tobacco products be purchased for patients who smoke, through the hospital or local shop and not issued to wards from hospital stocks. Also, a smoking cessation programme be put in place for patients.
8. Renewed efforts be made to recruit professional staff e.g. psychologists, occupational therapists and social workers to provide a multi-disciplinary service.
9. A risk management strategy be put in place which would ensure regular safety audits.
10. Rushbrook, St. Joseph's and St. Vincent's community residences be refurbished.
11. The seclusion room at Dun na Rí (Unit 11) be brought up to an acceptable standard.
12. The windows at the Carriglea Unit be painted.

CHAPTER THREE

Midland Health Board

LAOIS/OFFALY MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 25 SEPTEMBER, 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 124,139 was divided into three sectors as follows:

Sector	Population
Portlaoise	44,845
Tullamore	44,629
Birr	34,665

The Laois/Offaly service provided general adult psychiatric services and specialist services in later-life psychiatry through a range of sector-based day and rehabilitation facilities and in-patient services at St. Fintan's Hospital, Portlaoise.

IN-PATIENT CARE

In-patient care was provided with 110 beds in one female, one integrated and two male wards.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	13	7	3	—	23	28.4
3-12 Months	—	—	5	3	4	2	14	17.3
1-5 Years	—	—	2	9	1	1	13	16.0
> 5 Years	—	—	5	13	5	8	31	38.3
All Lengths of Stay	—	—	25	32	13	11	81	100
% of Total	—	—	30.9	39.5	16.0	13.6	100.0	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
4	35	—	18	8	1
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
—	7	2	6	—	81

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	42	30	72
Temporary	1	4	5
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	43	34	77

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
688	5.5	161	23.4	92.3	7.7	697	5

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	3	32	288
Day Centres	4	68	311
Out-patient clinics	10	380*	1,443

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
12	59	3	20	2	32

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
13	20.5	136.5	85.6	17

COST

The cost of the Laois/Offaly Mental Health Service was €14.5 million in 2002.

GENERAL COMMENTS

The current concern of this service and the Inspectorate was the possession and opening of the acute psychiatric unit at Portlaoise General Hospital. On completion, this unit had been handed over by the Midland Health Board to the general medical services so that they could vacate their wards in the main hospital while these were being refurbished. This process had now been completed. Some remedial work, re-decoration and the completed

commissioning for psychiatric occupation would then ensue. It was hoped that the current Inspectorate might see the unit in action before the end of 2003. Two admission wards in St. Fintan's Hospital would then close.

The Laois/Offaly service had acquired specialised services for later-life psychiatry, shared services with Longford/Westmeath for the psychiatry of intellectual disability and had a limited input from the substance misuse service based in Longford/Westmeath and was seeking a service for rehabilitation. The multi-disciplinary nature of the service had been enhanced by the recruitment of further social workers, psychologists and occupational therapists so that there was now almost one of each per sector and per sub-speciality.

The physical infrastructures in the sectors were at differing stages of development; the Birr sector was least satisfactory with inadequate day hospital/day centre/mental health centre/sector headquarters facilities. However, there was an adjacent care centre for the elderly that was to be vacated in the near future and this was being considered as an alternative. There was a reasonable premises available at Tullamore, which carried out day-work but required a more clearly defined and executed acute function. The day centre at Portlaoise had moved to the former activation and recreational premises at the rear of St. Fintan's Hospital, freeing up the new premises in the Portlaoise shopping mall to function as a day hospital and sector headquarters. However, the premises was small and ill-adapted for dealing with acutely ill patients. This situation was not helped by the holding of out-patient clinics there as well. Staff accommodation, with the provision of a kitchen and dining room, also impinged on patient space. The day centre premises would make a better acute day hospital because of the larger spaces available for disturbed persons. However, the location on the hospital campus was not ideal for either a day hospital, or a day centre.

There were 77 patients in residence in St. Fintan's Hospital on the day of inspection; 41 in the admission wards. Of these six were long-stay and would be accommodated in the rehabilitation ward. This would lead to a total of 27 rehabilitation patients, all of whom were suitable for community-based residential accommodation of varying levels of support were this available — currently it wasn't. However, the Inspectorate understood when funds became available accommodation for these persons would be built on the St. Fintan's Hospital campus. The Inspectorate had no difficulty with a rehabilitation residence being in this location under the care of the forthcoming rehabilitation team, but felt that the remainder of the accommodation should be community-based. Ten elderly males remained in the hospital and the intention was to consider making this unit gender-integrated to accommodate a small number of elderly females. As soon as possible these elderly persons would be given continuing care at Shaen and Mountmellick Hospitals, or in nursing homes; these organisational and clinical matters would be the responsibility of the specialised later-life service. These moves would lead to the closure of St. Fintan's Hospital as a psychiatric hospital. The Inspectorate understood that the hospital building would then be used to accommodate administrative and clinical functions.

The 50 beds provided in the new acute unit were generous, even if six were reserved for the later-life service for acute assessment purposes. The Inspectorate felt that a more

selective and restricted admission policy should be put in place with more emphasis on outreach and domiciliary intervention styles of practice and with, in conjunction with the specialised substance abuse service, the elimination of admitting patients for alcohol detoxification.

There was a need for the construction of footpaths around the Monreasa residence and some improvements in the entrance roadway. The residence itself required extensive internal and external redecoration.

In 2002, there were 53 patients admitted on temporary admission orders. Ten patients admitted as voluntary were re-graded to temporary and 19 admitted as temporary were re-graded to voluntary during their period of hospitalisation. There were no extensions of temporary admission orders during 2002. In addition to the 688 admissions to St. Fintan's Hospital in 2002 a further 68 patients were lodged overnight at the hospital but not formally admitted. Also in 2002, seven patients were transferred from St. Fintan's Hospital to St. Brigid's Hospital, Shaen and a further three female patients were transferred to St. Vincent's Hospital, Mountmellick. One patient was transferred from St. Fintan's Hospital to St. Loman's Hospital, Mullingar. In 2002, 26 patients took their own discharge from the hospital against medical advice. Aftercare procedures were in place for all patients if deemed appropriate. There were five deaths in St. Fintan's last year and there were six episodes of serious self-harm.

There were 41 episodes of seclusion involving 14 patients in St. Fintan's Hospital in 2002. A seclusion register was maintained with the full signature of the authorising medical officer recorded. Fifteen-minute nursing observations of all patients placed in seclusion were appropriately recorded. The seclusion facilities offered reasonable privacy for patients; however, these facilities will close with the relocation of the acute unit to the local general hospital. All nursing and medical documentation in relation to seclusion episodes were cross referenced to the special seclusion register. Patients placed in seclusion should have an unrestricted view of a clock from the safe room.

There were 98 spans of special nursing supervision involving seven patients during 2002. This was a significant reduction from the 1,158 spans of special nursing involving 21 patients at the same hospital during 2000. The revised nursing observation policy and procedure which introduced prescribed recorded observation and provided increased choice and more flexibility to professional staff when tailoring care plans to suit individual patient needs had contributed significantly to the marked reduction in the use of one-nurse to one-patient special nursing supervision.

Out-patient clinics were held at nine locations. There were 380 clinic sessions at which 367 new patients attended. At end of 2002 there were 92 patients at Tullamore, 20 at Portlaoise and 13 at Birr on the out-patient waiting list. However, all patients were prioritised according to need and acutely ill patients were sent directly to hospital where an initial acute assessment was made. The facilities at Portlaoise and Tullamore were adequate; however, space was a problem at the Birr, Rathdowney, Abbeylax and

Mountmellick out-patient facilities. There were some difficulties in ensuring adequate confidentiality for patients at the Abbeyleix and Graiguecullen clinics where there was a need to provide improved soundproofing of interview offices.

There were 105 liaison consultations by consultant psychiatrists at Portlaoise General Hospital resulting in 11 admissions and 37 referrals to the psychiatric out-patient department. At the Regional Hospital Tullamore there were 39 liaison consultations by consultant psychiatrists resulting in nine admissions and 454 nurse-led liaison consultations resulting in 17 admissions and 45 referrals to OPD during 2002.

Five patients were prescribed ECT at St. Fintan's Hospital in 2002 and all documentary procedures were appropriately recorded.

There were 294 first time referrals to the Department of Later-life psychiatry and 33 admissions to the in-patient assessment beds at St. Fintan's Hospital. In addition, there were 12 admissions to long stay facilities; two of those were to Ward 6 at St. Fintan's Hospital, Portlaoise. There were 59 referrals to the day hospital of the Department of Later-life Psychiatry at Block Road, Portlaoise of whom 52 were first time referrals. In 2002, 190 consultations were made by the later-life consultant psychiatrist and 94 home domiciliary consultations made by other members of the multi-disciplinary team.

During 2002, 10 complaints to the Local Complaints Officer and 19 requests under the Freedom of Information Act, 1997 were made. There were no research projects governed by the Clinical Trials Act, 1987-1990 undertaken in the Laois/Offaly service in 2002. Of the 21 recorded accidents to patients seven resulted in minor injuries and nine were deemed serious. There were four recorded accidents to staff, two resulting in minor injuries. There was one recorded assault on a patient by another patient resulting in no detectable injury. Of the eight recorded assaults on staff during 2002, five required further medical intervention. The Clinical Director supervised the participation of the Board in the INSURE Suicide study in the region throughout 2002.

All patients, irrespective of their status must be informed of their rights under the Mental Treatment Act, 1945. Voluntary patients should be told if they wish to leave hospital they must discuss this with their consultant psychiatrist or in his or her absence the clinical nurse manager. Information on the rights of detained patients was prominently displayed in in-patient care areas and included in the comprehensive information leaflet for patients and relatives.

The management team for Laois/Offaly met regularly to review services and a summary of the annual review was included in a comprehensive report produced by the Midland Health Board. The local management, in partnership with the health board, was working on a revised mental health strategy in conjunction with the Irish Advocacy Network and all other relevant stakeholders.

Since the last visit of inspection there had been an audit of medication and prescribing patterns. Following on from this, revised prescribing standards were introduced. These

standards will be re-audited at some stage in the future. A new system, known as standard operating procedures, for revising and updating hospital policies, procedures, protocols and guidelines had been introduced.

A selection of medical notes was examined. Patient's names were clearly recorded on each continuation page and each newly-admitted patient had a full medical evaluation, including comprehensive admission notes and immediate management plan appropriately recorded. Written instruction was required on the filing of documentation within the clinical record. Time of entry should also be recorded using the 24-hour clock.

Nursing records examined contained relevant information relating to nursing observation of the patient and changes in the patient's condition. The biographical data sheet for each admission was completed satisfactorily, as was the physical nursing assessment, social profile and psychiatric nursing assessment and nursing care plan. There was also provision made within the nursing documentation for recording the discharge plan for the patient. Entries should be signed in full block lettering alongside the signature of the first entry.

The safety statement and safety procedures for the hospital adhering to the standards and procedures set by the Safety and Welfare of Work Act 1989, were all reviewed and updated and safety statements were introduced to all staff. Fire safety precautions at St Fintan's Hospital were satisfactory. A system should be put in place to ensure that the fire emergency equipment at the Monreasa House was checked annually to ensure it was in working order. Records of the annual checks should be kept and recorded on each appliance. The information leaflet informing residents of who to contact in an emergency with appropriate telephone numbers should be updated.

Three patients, two males and one female, were interviewed to ascertain their views on the level of service provided and to highlight areas where the local service may need to make changes to respond to patients' wishes. All were of voluntary status and were satisfied with the courtesy and helpfulness of staff and with the admissions process. They knew the name of their consultant psychiatrist and were pleased with the frequency of their consultations, often on a one-to-one basis. They were informed of the nature of their medical condition, including medication and treatment. They knew the name of their primary care nurse and had been involved in their care plan. They were all aware of their rights under the Mental Treatment Act, 1945 and had received a hospital booklet which described the complaints procedures.

Two patients were satisfied with the cleanliness and hygiene in the unit. However, one patient described the unit as "poor, rundown and dirty". All patients were happy with the quality and quantity of the food. One patient felt that the locker space for personal belongings was too small and had no key.

All the patients interviewed were satisfied with the activity area in the unit and participated in many of the therapeutic activities. When asked how they would like to see the services improved one expressed the desire to move to the new unit as soon as possible.-

RECOMMENDATIONS

It is recommended that:

1. The acute unit at Portlaoise General Hospital open without delay and the admission units at St. Fintan's Hospital close.
2. The rehabilitation ward at St. Fintan's Hospital be replaced by a rehabilitation residence or community-based unit in conjunction with further community-based accommodation for this group of patients.
3. In conjunction with recommendation 2 the recruitment of a multi-disciplinary rehabilitation team be proceeded without delay.
4. The small number of elderly patients in St. Fintan's Hospital be moved to specialised residential units appropriate for their continuing care.
5. Physical premises be procured or made available or existing premises modified for acute day hospital activity in all three sectors with particular emphasis on extending and strengthening the services in the Birr sector.

LONGFORD/WESTMEATH MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 7 MAY 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 105,000 was divided into three sectors as follows:

Sector	Population
Mullingar	48,631
Longford	31,069
Athlone	25,300

The Longford/Westmeath service provided general adult psychiatric and specialist later-life psychiatric services through a range of community-based services and in-patient services at St. Loman's Hospital, Mullingar.

IN-PATIENT CARE

In-patient care was provided with 184 beds in four male and three female wards.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	15	13	5	6	40	23.4
3-12 Months	—	—	8	5	2	3	18	10.5
1-5 Years	—	—	10	9	7	10	36	21.1
> 5 Years	—	—	9	24	20	24	77	45.0
All Lengths of Stay	—	1	42	51	34	43	171	100.00
% of Total	—	0.6	24.6	29.8	19.9	25.1	100.00	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
10	92	3	31	10	2
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
8	8	—	7	—	171

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	90	64	154
Temporary	9	9	18
P.U.M.	3	1	4
Ward of Court	8	2	10
Total	110	76	186

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
795	7.6	231	29	88.4	11.6	805	16

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	3	Non-specific	239
Day Centres	4	Non-specific	187
Out-patient clinics	5	303*	1,336

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
6	26	3	25	3	38

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
14	27.5	211	132.55	18.7

COST

The cost of the Longford/Westmeath Mental Health Service was €18.4 million in 2002.

GENERAL COMMENTS

There had been some encouraging developments in this service during 2002. The range of specialised services offered had expanded and more were contemplated, new community initiatives were being considered and in-patient accommodation at St. Loman's Hospital had been improved.

The later-life psychiatric service had established a headquarters and a limited day hospital operation and had recruited the nucleus of a multi-disciplinary team. However, requirements included a day facility at Athlone, a small acute assessment sub-unit in the proposed general acute unit at Mullingar General Hospital and appropriate continuing care facilities based perhaps on an upgraded and designated St. Brigid's unit as one component of a generic and integrated service for the elderly of the area. In the meantime, the Inspectorate was pleased to see the service proceeding on a pragmatic basis.

A consultant-led substance abuse service had been put in place on a temporary basis for the catchment area. A consultant post in the psychiatry of intellectual disability had been filled on a temporary basis with sessional responsibility at the centre at Monasterevin and with the aspiration of providing an integrated service to the region. There was a need for specialised liaison services to the three general hospitals in the catchment area but particularly at Mullingar. It was the Inspectorate's view that priority should be given to setting up a rehabilitation team for enduring mental illness.

With regard to community development, the Inspectorate welcomed the proposed extension and development of the St. Vincent's site at Athlone, a number of elements of which will be relevant to psychiatry. Perhaps the most significant of these was the plan for a large and comprehensive polyclinic with accommodation for a sector headquarters, mental health centre and acute day hospital for the sector. This was urgently needed given the constriction and limitations from a functional point of view of the current premises. There was also a commitment to re-define and re-configure the Longford day facility operation. The Inspectorate was pleased to learn that the housing authority was making two houses

available to the mental health service in close proximity to existing accommodation in Longford.

St. Loman's Hospital, whatever its intrinsic architectural merit, was a grim structure which was not helped by the virtual total neglect of the grounds, evident on this visit. Inside, though, there had been some improvements, particularly in the case of St. Edna's ward, where a new enthusiasm prevailed: the ward was, under normal circumstances, open and seclusion had practically ceased. However, the female admission unit was in unsatisfactory accommodation on the second floor, awaiting transfer back to the admission unit when that was refurbished. The male admission unit had been refurbished and this had resulted in considerable improvement in the previously unacceptable conditions. Nevertheless, these improvements fell a good deal short of what was appropriate in a modern acute admission facility and should be regarded as a stop-gap only, with the unaltered goal being to set up a unit in Mullingar General Hospital.

In 2002, there were 92 patients admitted on temporary admission orders, a reduction of 23 from the previous year; 15 patients admitted as involuntary patients were re-graded to voluntary status, 11 patients admitted as voluntary patients were re-graded to involuntary during their hospital stay. There were 14 extensions of involuntary admission orders during 2002. Also in 2002, 76 patients were lodged overnight in St. Loman's Hospital but not formally admitted, an increase of 49 patients from the previous year.

During 2002, 123 patients took their own discharge from the hospital against medical advice. Appropriate follow-up procedures were available for those patients, if deemed clinically appropriate. A multi-disciplinary pre-discharge plan documentation was under consideration at the time of the visit.

There were 16 deaths in St. Loman's Hospital last year, all from natural causes. There were two recorded incidents of serious self-harm. In 2002, ten patients became new long-stay; four of those were aged 65-years or over.

There were 182 accidents to patients and 22 accidents to staff in 2002; two of the accidents to patients and one accident to a staff member were deemed serious, 59 resulted in minor injuries. There were 19 assaults on patients by other patients and 16 assaults on staff; 16 of the staff assaults and 13 of the patient assaults resulted in minor injuries.

The Department of Later-life psychiatry commenced operation during 2002 and at the end of the year there were 171 on the register; there were 557 referrals, of which 180 were first referrals and 377 return referrals. During 2002, 20 patients were admitted to the four assessment beds in the admission unit complex and a further six patients were admitted to the St. Brigid's block.

Fourteen patients were prescribed ECT in 2002, which was administered in the day ward of Longford/Westmeath General Hospitals. Records were appropriately kept in the clinical notes of discussions with patients on the nature of ECT prior to the signing of the consent form. A pre-ECT nursing checklist was completed satisfactorily. A post-ECT

nursing checklist should be introduced and vital signs immediately post-ECT should be recorded.

During 2002, two patients were placed in seclusion in St. Edna's Ward involving two episodes — a substantial reduction from previous years. An appropriate seclusion register was maintained and 15-minute nursing observations of patients appropriately recorded. It was not possible to check the nursing and medical documentation with the special seclusion register as the patients had been discharged from the hospital. Patients whilst in seclusion should have an unrestricted view of a clock. The seclusion policy, which was undated, should be reviewed and follow the format of the clinical records policy, which was comprehensive.

During 2002, 12 patients were placed on one-nurse to one-patient special supervision and there were 430 spans of special supervision of ten hours or more; 147 patients were placed on prescribed observation.

Statistical data relating to liaison consultations for 2002 was not available, due to the absence of an appropriate referral form. This had now been rectified and a new liaison psychiatry referral form had been introduced at Longford/Westmeath General Hospital in tandem with new policies and procedures relating to liaison consultations. The aim of the new policy was to rationalise routine referrals to two assessment periods per week, although urgent cases would be assessed on clinical need. Initial records appear to estimate that there were 330 liaison consultations at Longford/ Westmeath General Hospital during the year. The service was considering establishing a liaison psychiatric nurse service at Mullingar General Hospital, similar to the service introduced in recent years at Tullamore General Hospital.

There were no research projects governed by the Clinical Trials Act 1987-1990 undertaken in this service in 2002. Six requests for information under the Freedom of Information Act, 1997 and one complaint was made to the local complaints manager in 2002. All appear to have been dealt with satisfactorily.

Information on complaints procedures and on patients' rights under the Mental Treatment Act, 1945 was prominently displayed at each clinical location. All patients irrespective of their status should be informed of their rights. Voluntary patients should be told if they wish to leave hospital they must discuss this with their consultant or in his or her absence the clinical nurse manager. An entry should be made in the patient's documentation that an oral and written explanation had been given with an indication of the patient's understanding.

The Midland Health Board conducted an audit on hospital admissions for alcohol-related disorders as the percentage of such admission to this service was higher than the national average. The results of this audit emphasised the ineffectiveness of inpatient alcohol detoxification, in view of the high re-admission rate and the inappropriateness of many admissions. Since August 2002, all referrals to the drug and alcohol service from the sectors teams were invited to attend daily for an outpatient alcohol detoxification programme.

Over 80 per cent of the 31 inpatients asked expressed a preference for an outpatient detoxification programme if one were available and accessible. At the time of this visit, the Inspectorate was shown planning proposals for an outpatient alcohol detoxification pilot programme. The commencement of this programme would be welcomed by the Inspectorate.

There was no local written policy for the ordering, prescribing, storing and administration of medicines. All wards had a copy of a comprehensive Midland Health Board protocol relating to medical preparations for registered nurses dated July 2002. Prescription cards were all dated individually but required the signature in full. There was an increased risk factor of drug error at a number of locations where it was noted that discontinued prescriptions were greater in number than current prescriptions.

The importance and value of hospital policies, procedures and similar documentation had been recognised. A number of new policies and procedures were in draft form and a number of nursing policies had been introduced to the clinical areas since the previous visit. A computerised index of all current policies should be kept and revised and superseded policies removed. The Inspectorate welcomed the new policy on special nursing and the guidance document on the management of illicit drug use/drug-related incidents. The newly-introduced policy and procedure relating to patients absent without official leave should contain the details of the person responsible for taking charge of such issues.

The safety statements were dated 1991 and the safe work practice sheets dated 1993, with one safe work practice sheet on violence dated 1995. The safety statements referred to were the generic Midland Health Board safety statements; the hospital and Department safety statements were all undated. There was a health and safety committee and the last meeting was held in March 2003. This committee should review and update all health and safety statements. There were written fire orders at all locations and an appropriate fire detection system installed. All drugs were within date and oxygen and suction and other emergency equipment working satisfactorily. Certain units within St. Loman's Hospital had an appropriate personal alarm system installed for the protection of staff and patients. There was a written policy on the panic alarm system dated 1996 and all staff on this occasion were wearing their appropriate handsets. It was noted that many of the personal alarm units at the main admission unit were malfunctioning — this matter should be addressed.

The Inspectorate welcomed the introduction of an audit system and note that the Service Managers were auditing clinical notes, prescription sheets and prescribing methods. The nursing care plan used the 'Roper' model of nursing comprised historical and personal data, assessment details etc. The standard of nursing documentation within St. Loman's Hospital had improved considerably in recent years. The nursing records were kept in separate folders from the medical records. A comprehensive activities and daily living chart was used as a reference tool for nurses. The biographical data sheet for each admission checked at three locations was well completed. A comprehensive discharge planning checklist was in use, in tandem with the nursing notes. On the nursing care plan assessment

and planning sheet it was noted that the section for recording the involvement the patient may have had with the community mental health services was not always completed.

The quality and choice of food was satisfactory as was the hygiene of food preparation areas. The provision of the evening meal at 4.30-4.45 was in the opinion of the Inspectorate too early and should be reviewed.

Newly-admitted patients were interviewed as to their views of the service they received. There was general agreement that the lack of activity was soul-destroying and that time hung heavily with little to do. There was also consensus that sometimes the explanations for the requirements and frequency of the need for medication seemed to differ between doctors and nurses. Others complained that they did not appear to have a personally identified nurse to whom they could relate on an individual basis.

RECOMMENDATIONS

It is recommended that:

1. The proposed development at Athlone proceed as rapidly as possible and provide the maximum by way of mental health services including sector headquarters, mental health centre and day hospital.
2. The removal of asbestos from the St. Brigid's block proceeds to allow the refurbishment of the female admission unit and its transfer back from its present location.
3. Planning proceed towards the provision of an acute psychiatric unit in Mullingar General Hospital.
4. A specialised rehabilitation team be established.
5. Adequate premises be acquired for the later-life service to enable it to carry out its work on a comprehensive catchment area basis.
6. St. Brigid's wards be de-designated and this service be integrated with the generic services for the elderly in the area.
7. A satisfactory occupational therapy premises for acute and other patients be provided.

CHAPTER FOUR

Mid-Western Health Board

CLARE MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 10 SEPTEMBER, 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 103,277 was divided into four sectors as follows:

Sector	Population
East Clare	33,039
West Clare	20,243
North Clare	17,720
South Clare	32,275

IN-PATIENT CARE

In-patient care was provided at the acute psychiatric unit in Ennis General Hospital, which had 40 beds and at Orchard Grove which had 19 beds. Specialist services for later-life psychiatry and for rehabilitation psychiatry were provided in this service. There was also a range of community-based services.

Age and Length of Stay of all Patients at 31.12.02 — ACUTE UNIT, ENNIS GENERAL HOSPITAL

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	2	21	12	5	—	40	78.4
3-12 Months	—	2	4	5	—	—	11	21.6
1-5 Years	—	—	—	—	—	—	—	—
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	4	25	17	5	—	51	100
% of Total	—	7.8	49.1	33.3	9.8	—	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	14	2	14	2	5
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
2	7	4	1	—	51

Age and Length of Stay of all Patients at 31.12.02 — ORCHARD GROVE

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	—	—	—	—	—	—
3-12 Months	—	—	—	—	—	—	—	—
1-5 Years	—	—	1	1	—	—	2	10.5
> 5 Years	—	—	2	12	2	1	17	89.5
All Lengths of Stay	—	—	3	13	2	1	19	100
% of Total	—	—	15.8	68.4	10.5	5.3	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	14	—	—	—	1
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
1	—	—	3	—	19

Status of In-Patients on date of Inspection 2003 — ACUTE UNIT, ENNIS GENERAL HOSPITAL

Status	Male	Female	Total
Voluntary	13	13	26
Temporary	7	10	17
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	20	23	43

Status of In-Patients on date of Inspection 2003 — ORCHARD GROVE

Status	Male	Female	Total
Voluntary	13	—	13
Temporary	—	—	—
P.U.M.	3	—	3
Ward of Court	—	—	—
Total	16	—	16

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
518	5.0	128	24.7	86.1	13.9	511	—

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	4	49	943
Day Centres	4	80	189
Out-patient clinics	12	708*	1,204

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
6	26	6	45	7	149

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
13	11.1	221	67.25	19.1

COST

The cost of the Clare Mental Health Service was €18.5 million in 2002.

GENERAL COMMENTS

The Clare service had made significant progress in the past few years, exemplified by the closure of Our Lady's Hospital, Ennis and the community resettlement of its former residents on the opening of the new psychiatric unit at Ennis General Hospital. An enthusiasm had been generated by this and, with it, a commitment to move forward on other fronts. There was now a specialised team for later-life psychiatry in place with an acute assessment unit in the Ennis unit and continuing care accommodation in St. Joseph's Hospital, also in Ennis. St. Joseph's had two units, one staffed by mental health service nurses, the other by the St. Joseph's nursing staff. The beds at Cappahard should also be available for continuing care purposes for this service. However, the residents should have their general health care provided for by general practice, in association with the generic health care services for the elderly of the county. As patients in community care settings of the mental health services became elderly and needed services because of physical disabilities associated with their age they should not be brought back to residential facilities, such as Cappahard, unless there was a significant psychiatric dimension to their disability.

There was also a specialised rehabilitation team in place working towards full multi-disciplinary representation. This team had taken on responsibility for all community residences, including the rehabilitation residence, Orchard Grove, Ennis, a premises which needed some upgrading. Because of the consequences of long-time institutionalisation in Our Lady's Hospital, the residents in Orchard Grove presented quite a challenge for staff. The transfer of other patients to The Orchard in Kilrush had given these former residents of

the hospital much improved accommodation. The same was true for the intellectually disabled persons who had been moved to the new high-quality residence in Spanish Point and whose level of behaviour had improved immeasurably since transfer.

There was still some room for structural improvement in all sectors. In Shannon, more accommodation had been made available to the service in the health centre. This premises should now be used as an acute day hospital and sector headquarters by moving the out-patient clinic and day centre activity elsewhere in the sector. In North Clare, a house was to become available to reinforce and extend the day provision at Ennistymon and, if possible, to establish an acute day hospital and sector headquarters at this location. Recent work had improved the services at both Kilrush, for West Clare, and at Ennis for East Clare. An administrative service had been established on that part of the Our Lady's campus retained by the service and this premises had been refurbished and decorated for offices for the senior personnel of the service.

The Inspectorate had some concerns about the high-observation area in the psychiatric unit in Ennis General Hospital. The Inspectorate felt that nine beds were too many for this area and as a result many patients were unnecessarily placed in this locked area. Given the existing situation, it was difficult to comprehend why the entrance door to the unit as a whole was locked. Additionally, it was disappointing to find that almost 50% of the patients in the unit were involuntary and that there did not seem to be any systematic process of review of their status in place.

The location and layout of community residences visited were suitable for their stated purpose. All were accessible, safe and well maintained. The Inspectorate welcomed the extensive remodelling and refurbishment of the Kilrush Day Hospital where the overall physical standards achieved were high. Some redecoration was required at the Delginis high-support residence at Shannon. Each unit within the community service should produce a written statement of purpose and function. Each patient should be provided with a statement of the terms and conditions of occupancy, including the weekly scale of charges.

The out-patient facilities within the Clare catchment area were adequate, providing appropriate privacy and confidentiality for patients and their families. An appointment system was in operation and there was a waiting list of five days in the north, south and west sectors and four- to six-weeks in the east sector. Patients on the waiting list were prioritised by consultant psychiatrists. All patients requiring emergency consultation were seen as a priority at the day hospital in Ennis.

There were 72 involuntary admissions to the acute psychiatric unit in 2002; all on temporary admission orders. This compared favourably with 2001 when 26 admissions were on PUM admission orders. The Inspectorate welcomed the change in practice with the relocation to the acute psychiatric unit. Eleven patients admitted as involuntary patients were re-graded to voluntary status and 13 patients admitted as voluntary patients were re-graded to involuntary while hospitalised. There were no extensions of involuntary admission forms during 2002. In 2002, nine patients took their own discharge from the service and procedures were in place for follow-up at the day hospital if deemed appropriate.

There were 10 recorded accidents to patients, eight resulting in minor injury and one recorded accident to a staff member in 2002; none were deemed serious. There were five recorded assaults on patients by other patients and none were deemed serious.

There were four complaints made to the local complaints/appeals manager and eight requests under the Freedom of Information Act, 1997. All appeared to have been dealt with satisfactorily. There were no research projects governed by the Clinical Trials Act 1987-1990, undertaken in the Clare Mental Health Service in 2002.

During 2002, there were 27 patients placed on one-nurse to one-patient special nursing supervision and there were 93 duty spans of special nursing supervision. This was a reduction from the 729 duty spans in 2001. There was a written policy and procedure for special nursing supervision. Special nursing was initiated and discontinued on the instructions of the patient's consultant psychiatrist.

In 2002, 28 patients were placed in seclusion involving 98 episodes. A seclusion register was maintained and the 15-minute prescribed recorded observations were appropriately recorded. However, the time of seclusion was not always recorded. Seclusion was authorised by consultant psychiatrists. Information on patient's response to seclusion during and after the event should be documented in the nursing notes. A multi-disciplinary review should be completed and documented for each episode of seclusion within 24-hours. All medical and nursing documentation relating to each seclusion episode should be easily cross-referenced to the special seclusion register. In a number of medical notes examined, the Inspectorate could find no entry relating to the seclusion.

Six patients were prescribed ECT in this service in 2002. The facilities for ECT comprise waiting, treatment and recovery areas and were satisfactory.

At the time of inspection, all policies, procedures and clinical guidelines remained under review. As mentioned in the Inspector's report for 2002 this service should consider providing an individual cover sheet detailing reference number, authors of the policy document, monitoring procedures, and detailing the reference documentation used as the evidence base for the policy. Revised and superseded policies should be removed from operation with a predetermined number kept centrally for future reference. Policy documentation should be incorporated into a formal audit process to enable assessment of efficacy and compliance.

The Inspectorate welcomed the auditing of medication and prescribing patterns and was pleased to learn of the improvement in practice following the audit. It was hoped that the standard of medical audit would be maintained with a clear programme and process for dissemination of audit results. Non-medical staff should be aware of the audit findings and the implications for them in their day-to-day practice.

Fire safety procedures in this service were satisfactory. There were written fire orders at all locations and appropriate evacuation plans for residencies and in-patient care areas.

The checking system to ensure all fire safety equipment operated effectively in emergencies was satisfactory with inspections recorded, dated and signed. Fire evacuation drills were carried out in all community residences on a monthly basis and appropriate records kept.

A number of clinical files were examined as part of this inspection. Each newly-admitted patient had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and clear management plan appropriately documented in the clinical notes. In all notes examined the patient's name was clearly recorded on each continuation page. However, it was difficult to determine whether entries were medical or nursing in some notes.

As mentioned in previous reports, the delivery of information on patients rights', especially to involuntary patients should be adequately recorded in the patient's case notes. A standardised form should be developed to record that information had been given to patients about their legal position.

All staff were familiar with the service policy in relation to patients absent without official leave. While the existing policy highlighted the immediate action to be taken when a patient was missing, a revised policy should state who had responsibility for taking charge of the search, etc.

A number of nursing records were examined. The biographical data sheet was well completed and there was a statement in the nursing assessment giving a physical description of the patient. However, the section on drug sensitivities and allergies was not always completed. Ideally, the nursing records should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment. Similarly, evaluations of the nursing care plan should include the patient's views about progress. Provision should also be made for the recording of the patient's primary nurse or team allocated nurse in the nursing documentation. It was noted that some staff always recorded time of entry using the 24-hour clock which was very satisfactory.

Three patients, two male and one female, randomly selected, were interviewed to assess their opinion of the care provided. All were voluntary and had previous hospital admissions; one in another country. They were satisfied with the courtesy and helpfulness of staff, were introduced to the professional team responsible for their care and knew the name of their consultant psychiatrist. However, one felt that some staff were patronising. All were pleased with the frequency of consultation with their consultant psychiatrist and the ease of accessibility to them. Two patients felt that their illness had not been properly explained to them. They were not aware of any individual care plan or if there was a primary nurse responsible for their care. One said that there was a nurse primarily responsible for his care but that nurse changed from day-to-day. All patients said they had not been informed about their rights under the Mental Treatment Act, 1945 and neither were they aware of any formal procedure for registering a complaint. All patients said they would like to get written information on all medications used. When asked for their

suggestions for the improvement of the services provided two said they would like to be offered the services of a psychologist/counsellor.

RECOMMENDATIONS

It is recommended that:

1. The additional space in the Shannon Health Centre premises be adapted to serve as an acute day hospital and sector headquarters.
2. The premises apparently becoming available in Ennistymon be acquired to enlarge the mental health service accommodation in this town for the North Clare sector with a view to providing an acute day hospital and sector headquarters.
3. Consideration be given to moving the two entrance doors to the high observation area in the Ennis Acute unit inwards so that the three bedded rooms which were part of that area become integrated into the general area leaving just three single rooms within the high observation area which should be quite adequate.

LIMERICK MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 30 SEPTEMBER, 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 175,304 was divided into five sectors as follows:

Sector	Population
North City	28,925
South-East and Limerick City	45,534
South-West City, Adare and Croom	44,962
Newcastle West (Rural)	33,545
Kilmallock (Rural)	22,338

IN-PATIENT CARE

In-patient care was provided at St Joseph's Hospital, Limerick, which had 156 beds in three male, two female and two integrated wards, and at the 49 bed acute psychiatric unit in Limerick Regional Hospital. Specialist services were provided for later-life psychiatry and community services were provided through a network of sector-based services.

Age and Length of Stay of all Patients at 31.12.02 — ST. JOSEPH'S HOSPITAL AND ACUTE UNIT.

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	1	3	21	15	4	3	47	23.7
3-12 Months	2	—	8	9	3	—	22	11.1
1-5 Years	—	—	10	15	5	4	34	17.2
> 5 Years	—	—	8	37	24	26	95	48.0
All Lengths of Stay	3	3	47	76	36	33	198	100
% of Total	1.5	1.5	23.7	38.4	18.2	16.7	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
7	91	3	24	18	10
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
3	8	1	31	2	198

Status of In-Patients on date of Inspection 2003 — ACUTE UNIT

Status	Male	Female	Total
Voluntary	12	15	27
Temporary	5	8	13
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	17	23	40

Status of In-Patients on date of Inspection 2003 — ST. JOSPH'S HOSPITAL

Status	Male	Female	Total
Voluntary	79	54	133
Temporary	6	5	11
P.U.M.	3	1	4
Ward of Court	2	1	3
Total	90	61	151

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
722	4.1	194	26.9	83.1	16.9	702	13

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	5	125	1,593
Day Centres	5	100	191
Out-patient clinics	22	1,232*	2,168

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
5	30	6	40	4	76

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
14	23	271	75.04	14

COST

The cost of the Limerick Mental Health Service was €25.9 million in 2002.

GENERAL COMMENTS

The Limerick mental health service was a service of stark contrasts. There had been considerable initiatives and developments on the community front. These were continuing as exemplified by the substantial on-going re-modelling and extension of the day hospital and sector headquarters at St. Annes, Roxborough and at Kilmallock. In addition, very substantial advances were made in the other sectors in recent years, to which must be added the imminent transfer to the newly-acquired residential premises Inis Gile, at Parteen for the elderly patients from St. Teresa's unit at St. Joseph's Hospital and its closure. These, together with the creation of specialised services for the elderly, child and adolescent psychiatry, liaison psychiatry and the about-to-be set up rehabilitation service, the transfer of elderly patients to St. Camillus Hospital and of intellectually disabled persons to Lisnagry, represented considerable achievements.

On the other hand, the continued presence of St. Joseph's Hospital with its substandard accommodation where doors were locked and some staff still wore white coats, was a reminder of standards of care that should have disappeared. In mitigation it should be borne in mind that as recently as 15-years ago there were 800 patients in the hospital, in even more deplorable conditions and that current capital difficulties prevented existing patients being moved to community care. St. Mary's ward managed to provide exemplary standards of care for elderly females in a homely and cheerful, if somewhat old-fashioned, atmosphere and environment.

Almost half the patients in St. Joseph's Hospital were elderly and apart from St. Mary's Ward there were 36 in poor accommodation in St. Teresa's ward. These patients had been ready to transfer to new and far superior premises, at Parteen, which was acquired and adapted by the Health Board for a cost of approximately €2 million. This had not happened because of the failure of the two nursing unions to accept the generous movement package offered to them by management. As so often happened currently and in the past, patients' welfare had been secondary to the benefits that unions had sought on behalf of their members. However, management was confident that settlement would soon be reached and that this facility would open and St. Teresa's would shortly close. There would

still, however, remain a further 15 to 20 elderly females in St. Teresa's ward for whom alternative placement would be necessary, to accelerate the closure of St. Joseph's Hospital. Having moved many intellectually disabled persons to Lisnagry, a specialised intellectually disabled service, with reported considerable improvement in their clinical and behavioural condition, the service was now concentrating on completing a similar exercise in relation to the resettlement of approximately 10 intellectually disabled persons still in St. Joseph's Hospital.

Apart from these two categories of patient, there were also long-stay functionally ill patients in St. Joseph's Hospital in urgent need of rehabilitation and community resettlement. The upcoming establishment of a specialised, multi-disciplinary rehabilitation team was a most encouraging step in facing this and other challenges. However, this team will require the necessary infrastructure, in particular, the homes and community residences for resettlement. It was not clear to the Inspectorate that the Board had worked out an incisive and strategically planned and timed programme for the closure of the hospital and the alternative purpose to which it and its lands might be put.

The acute unit, 5B, at the Regional Hospital, was undergoing work to comply with health and safety requirements. More fundamental re-modelling was required to provide it with appropriate close observation facilities and a suitable acute assessment area for the elderly service. These issues were very relevant in light of the continuously locked and closed nature of the unit and the extremely high cost of and inordinate frequency of special nursing which had escalated during 2002.

Another matter of great concern to the Inspectorate had been the practice of accommodating young children, sometimes as young as 11 years, and sometimes as many as three simultaneously, always special-nursed, day and night, in the unit. While the Inspectorate acknowledged that the lack of adequate in-patient accommodation for child and adolescent services was a serious matter, the placement of children in adult units or wards was inappropriate.

The unit now had 41 beds, down from the complement of 50, because of the ongoing work referred to earlier. This should have been a sustainable number had there been a tightly operated admission policy such that all admissions were consultant-determined and alcohol dependence was not accepted for detoxification. With the recent appointment of a liaison consultant and crisis team and a greater commitment to outreach community work it should be possible to reduce and shorten length of admission by the substitution of more community-based alternatives. This being so, the issue for the Mid-Western Health Board as to whether the inpatient needs of Tipperary North Riding could be served by Limerick should be seriously considered as an alternative to the costly and, in multi-speciality terms, unsustainable Nenagh provision.

Of the 722 admissions to the Limerick mental health service, 55 were admissions of persons resident outside of the Limerick catchment area and 26 of those were first time admissions, a further seven were persons of no fixed abode. There were 107 temporary admissions; seven patients had their temporary admission orders extended, 17 patients

admitted voluntarily were re-graded to temporary and 17 patients admitted involuntarily were re-graded to voluntary status while hospitalised. A further 15 admissions, nine male and six female were on person of unsound mind certificates (PUM) to the acute unit at Limerick Regional Hospital. These patients should have been re-graded to temporary status if involuntary admission was considered necessary. In 2002, 10 patients, eight male and two females admitted to the acute unit were aged sixteen years or under. Sixteen patients took their own discharge from the service against medical advice in 2002. Appropriate procedures were in place to follow up these patients if deemed necessary. There were 13 deaths in 2002, one by suicide and the remainder from natural causes.

There were 35 recorded accidents to patients at St. Joseph's Hospital and 32 recorded accidents to patients at the Department of Psychiatry, Limerick Regional Hospital in 2002. Two of the accidents at the Department of Psychiatry were deemed serious. There were 20 recorded accidents to staff in the entire service and two were deemed serious. There were 56 recorded assaults on patients by other patients at St Joseph's Hospital — an increase from 26 recorded in 2001; 35 resulted in minor injury and five were deemed serious. Of the 93 recorded assaults on staff 16 resulted in serious injury and a further 31 resulted in minor injuries.

In 2002, 15 patients at St. Joseph's Hospital were placed on one-patient to one-nurse special nursing supervision and there were 123 episodes of special nursing supervision involving duty spans of ten hours or more. There were 2,550 episodes of special nursing supervision involving duty spans of ten hours or more at the Department of Psychiatry, Limerick Regional Hospital. There were two patients on special nursing supervision at the time of the visit and the Inspectorate was informed that there were occasions when there were nine patients on special supervision at this unit. There was a policy that all children admitted to the unit be placed on special nursing supervision. Special nursing supervision appeared to be used more frequently in the Limerick mental health service than any other services visited. There was a need for a comprehensive review of existing nursing practices to address the issue of the high levels of special nursing supervision. Consideration should be given to the provision of an improved observation area for patients at risk.

During 2002, there were 28 recorded complaints and 11 requests under the Freedom of Information Act, 1997. Written guidelines on the handling of complaints alleging abuse/ill treatment/neglect of patients in the mental health services was available and included in the hospital policy manual. Notices communicating this information should be prominently displayed in in-patient care areas.

There were two research projects governed by the Clinical Trials Act, 1987 — 1990 undertaken in the Limerick mental health service in 2002. Information relating to this research was not available at the time of the visit of inspection but service providers undertook to supply this information when available. One patient was referred for psychosurgery outside the State, however, the Inspectorate were informed that following further consultation the patient concerned decided not to follow through with the procedure.

A seclusion register was satisfactorily maintained. There were nine episodes of seclusion at Unit 10, St. Joseph's Hospital involving two patients in 2002 and 19 episodes involving three patients at Unit 10, St. Rita's since March 2003. All of the nursing and medical documentation in relation to seclusion was cross referenced to the special seclusion register. Patients should have an unrestricted view of a clock while in seclusion. The policy and procedure relating to the use of seclusion required review and the seclusion room needed modernisation.

In 2002, 41 patients were prescribed ECT treatment at the Department of Psychiatry, Limerick Regional Hospital (one patient from St. Joseph's Hospital): the facilities were satisfactory with appropriate waiting, treatment and recovery areas. Documentary procedures relating to this treatment were also satisfactory. Information relating to the effectiveness of ECT using the Montgomery and Asberg depression rating scale which commenced in February 2002 was completed during the year but the results were not available at the time of inspection.

There were 240 consultations by the liaison consultant psychiatrist resulting in 12 patients being admitted to the psychiatric unit and 26 referred to the mental health out-patient department. During 2002, 72 patients admitted to Unit 5B, Department of Psychiatry had been transferred to St. Joseph's Hospital.

There were 394 first time referrals to the Department of Later-life Psychiatry, resulting in 13 admissions to the in-patient assessment beds at Unit 5B. There were a further 110 admissions to Unit 9A at St. Camillus' Hospital. There were 15 patients on the day hospital register of the Department of Later-life Psychiatry, 13 of whom were first referrals at the end of 2002.

The out-patient clinics operated by this service at St. Camillus Hospital and Kilmallock Day Hospital had 109 new attendees in 2002. This was in addition to the 341 domiciliary assessments by the consultant with special responsibility for this service. Apart from Foynes and Abbeyfeale, out-patient clinics were held at the day hospitals within each of the five sectors of the Limerick Mental Health Service. An appointment system was in operation with a waiting list of 84 patients for the Churchtown day hospital clinic at Newcastlewest, 257 for the Willowdale day hospital clinic at Raheen, and 242 at the Roxborough Road, St. Anne's day hospital. The approximate waiting time was four weeks. There were no waiting lists at the Kilmallock or Tevere day hospitals.

All patients, irrespective of their status, must be informed of their rights under the Mental Treatment Act, 1945 and amending legislation. Voluntary patients should be told if they wish to leave hospital they should discuss this with their consultant psychiatrist or clinical nurse manager. Information given to temporary patients on right of appeal and complaints procedures should be recorded in the clinical notes.

At the time of this inspection all policies, procedures, protocols and guidelines were under review by a policy review committee and a number of revised policies relating to the

recording of clinical information, drugs, management of violence and aggression, confidentiality and escorting patients had been ratified and introduced. Once new policies and procedures became effective a computerised index should be kept and superseded policies should be removed from operation. Revised and updated policies should be formally introduced to relevant staff ensuring an awareness and understanding of content. Personnel policies relating to bullying, grievance procedures, accidents to staff, other staffing matters should be kept separate from policies and procedures relating to the care and treatment of patients. Work was underway on the development of a site specific safety statement for each location at the time of our visit.

The “Oram/King” model of nursing was in use in this service. Records examined appeared to identify problems that had arisen and outlined actions taken by staff to rectify them. All entries were accurately dated; time of entry should be recorded using the 24-hour clock. All inputs were signed in full and the signature was accompanied by the status of the nurse. The biographical data sheet for each admission was completed comprehensively. Sections relating to drug allergies and drug sensitivities were appropriately recorded as was the patient’s height, weight and vital signs. Records examined reflected the involvement of patients in planning and making choices and decisions about their own care and treatment. Similarly, evaluations of nursing care plans included patients’ views about their progress.

Three patients, two male and one female were interviewed to assess their opinions on the psychiatric services provided. One of the male patients was a youth on his third period of admission. He was hospitalised for four months and resented being detained.

The two adult patients were very pleased with the courtesy and helpfulness of the staff, also the frequency of consultations and treatment they received from their consultant psychiatrist. Their psychological problems and therapies had been fully explained to them, as had their medications and their side effects. Both knew the primary nurse responsible for their care. However, neither was aware of any care plan in place for them, nor what their rights were under the Mental Treatment Act, 1945. One patient was aware of a complaints procedure as notices were prominently displayed. All patients were satisfied with the quality and presentation of the food. One patient was pleased with the activities provided by the occupational therapist and had participated in a cooking class on the day of inspection. However, one patient found the evenings and weekends boring and felt more appropriate activities should be organised for these times. The smoking room was described by one patient as awful. All were pleased with the hygiene and cleanliness of the bathroom and toilet areas.

With regard to the youth interviewed, as mentioned earlier, the Inspectorate’s view was that the unit was not suitable for a person of his age. The whole question of admitting children to this unit must be reviewed as a matter of urgency. This young boy should be in an adolescent unit with others of similar age group and where all therapeutic activities were geared to this age.

When asked for suggestions as to how the services might be improved one patient said she would appreciate less noise during the night.

RECOMMENDATIONS

It is recommended that:

1. All necessary steps be taken to provide alternative accommodation on a community basis to enable St. Joseph's Hospital to close for psychiatric usage.
2. The acute unit at Limerick Regional Hospital be adapted for close observation purposes, to reduce the level of special nursing and to enable the unit to function on an unlocked basis.
3. The practice of admitting children to the unit cease.
4. St. Teresa's ward be closed and patients re-located to the new residential premises, Inis Gile at Parteen.

CHAPTER FIVE

North-Eastern Health Board

CAVAN/MONAGHAN MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 13 AUGUST, 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 109,188 was divided into two sectors as follows:

Sector	Population
Monaghan Community Mental Health Team	52,772
Cavan Community Mental Health Team	56,416

The Cavan/Monaghan service provided adult psychiatric and specialist rehabilitation psychiatric services through a range of community-based services and in-patient services at Cavan General Hospital and St. Davnet's Hospital, Monaghan.

IN-PATIENT CARE

The acute psychiatric unit at Cavan General Hospital had 20 beds and St. Davnet's Hospital, Monaghan had 70 beds in two male and two female wards and one integrated ward.

Age and Length of Stay of all Patients at 31.12.02 — ST. DAVNET'S HOSPITAL, MONAGHAN

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	2	1	1	—	4	6.7
3-12 Months	—	—	—	—	2	—	2	3.3
1-5 Years	—	—	1	2	4	1	8	13.3
> 5 Years	—	—	—	11	6	29	46	76.7
All Lengths of Stay	—	—	3	14	13	30	60	100
% of Total	—	—	5.0	23.3	21.7	50.0	100	

In-Patient Population Diagnosis at 31.12.02 — ST. DAVNET'S HOSPITAL, MONAGHAN

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
6	33	1	6	8	5
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
—	1	—	—	—	60

Age and Length of Stay of all Patients at 31.12.02 — CAVAN GENERAL HOSPITAL

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	1	3	—	2	6	66.7
3-12 Months	—	—	1	1	—	—	2	22.2
1-5 Years	—	—	—	—	1	—	1	11.1
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	—	2	4	1	2	9	100
% of Total	—	—	22.2	44.5	11.1	22.2	100	

In-Patient Population Diagnosis at 31.12.02 — CAVAN GENERAL HOSPITAL

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
1	4	—	1	3	—
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
—	—	—	—	—	9

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	25	30	55
Temporary	7	3	10
P.U.M.	—	8	8
Ward of Court	—	1	1
Total	32	42	74

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
193	1.8	66	34.2	81.3	18.7	189	7

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	3	35	151
Day Centres	3	64	128
Out-patient clinics	6	754*	2,014

*No. of out-patient clinics held in 2002

Assertive Outreach Team

Number of Referrals	Number of First Referrals	Number of Patients on Register 31/12/2002
47	20	45

Home Treatment — Crisis Intervention Team

Number of Referrals	Number of First Referrals	Number of Patients on Register 31/12/2002
298	202	41

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
12	55	—	—	4	50

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
19	24.5	203.3	58.5	23.5

COST

The cost of the Cavan/Monaghan Mental Health Service was €18.5 million in 2002.

GENERAL COMMENTS

The Cavan/Monaghan service continued its sector-based delivery of general adult care within the framework of an acute community response service model. This had two components; one for Monaghan, based in St. Davnet's Hospital and the other based in the Cavan acute unit for that county. Also based in St. Davnet's Hospital, was a specialised community rehabilitation team that had begun by servicing Monaghan but had extended gradually to Cavan. Both embraced assertive outreach and domiciliary care as operational mechanisms. The teams were highly staffed and multi-disciplinary and the success of their efforts was reflected in the greatly reduced acute bed usage, which seldom reached twenty between the two locations. The rehabilitation team had acquired a high-support residence, recently built and to open shortly, with the resultant closure of two of the remaining wards in St. Davnet's Hospital.

A new primary care demonstration project premises was due to open shortly in Virginia, with a mental health component. A site owned by the Board in Bailieborough, which had been destined for the mental health service had not been utilised. Two badly needed extensive community developments, involving day hospitals and sector headquarters, one in Carrickmacross and the other in Cavan town, had been envisaged with National Development Funding but these were now in abeyance. An acute day hospital was required for Monaghan town and, in addition, a sector headquarters for East Cavan.

The later-life psychiatry service was operating satisfactorily. Acute assessment beds for this specialised service were provided in the acute psychiatric unit in Cavan General Hospital. A day hospital in the grounds of that hospital was required for this service to replace the existing facility in St. Davnet's Hospital. In addition to the specialised rehabilitation service the Inspectorate felt that a case should be made for a consultant team in the psychiatry of intellectual disability. These apart, there were now six consultants, four senior or specialist registrars, five social workers, four occupational therapists, three psychologists and 203 nurses in the service, so that by national standards Cavan/Monaghan was well provided for. There appeared to be inexplicably high levels of nurse staffing in some elements of the service; to take one of several possible examples, four nurses for five patients at night in the acute unit at St. Davnet's Hospital was noted. Perhaps this had some bearing on the fact that despite the small in-patient base of this service this latter still accounted for an estimated 40 per cent of current expenditure.

There remained a remarkable reliance on St. Davnet's Hospital for this service's needs. The Inspectorate found it difficult to comprehend why the acute admission unit in that hospital remained open. The case for its closure appeared unanswerable and the Inspectorate had advocated this year after year. Other examples of services based in St. Davnet's Hospital, which would be better community-located, included the day hospital for later-life psychiatry, the day centre and services for those patients coming in on a daily basis to the acute unit. The Inspectorate formed the opinion that the predominance of St. Davnet's in terms of service provision clinically and administratively might have been perceived by some staff as de-emphasising their own areas of operation.

In 2002, 36 patients were admitted on involuntary admission orders to the Cavan/Monaghan Mental Health Service; 24 were to the acute unit, Cavan General Hospital and 12 to the Monaghan Admission Unit. Three involuntary patients were re-graded to voluntary status and four voluntary patients in the Cavan unit were re-graded to involuntary status during the course of their hospital stay. During 2002, four patients had their temporary admission orders extended. Forty-seven patients were lodged overnight at St. Davnet's Hospital and nine of those were formally admitted.

During 2002 there were six accidents to patients with three resulting in minor injury at St. Davnet's Hospital and 36 accidents to patients at the Cavan unit, two deemed serious. There were 36 assaults on patients by other patients and 61 assaults on staff; none were deemed serious. Also during 2002, there was one accident to a staff member at St. Davnet's Hospital and nine assaults on staff at Cavan General Hospital unit, three resulted in minor injury and one deemed serious. There was one assault on a patient by another patient resulting in no detectable injury.

Four patients were placed on one-to-one special nursing supervision at the Cavan unit involving 58 episodes of duty spans of 10-hours or more. At St. Davnet's Hospital, three patients were placed on special nursing supervision with six duty spans involving 10-hours or more. Seclusion was not used in the Cavan/Monaghan Mental Health Service.

During 2002 there were two complaints by patients or patients' relatives to the local complaints manager and seven requests under the Freedom of Information Act, 1997. All were satisfactorily dealt with. There were no research projects governed by the Clinical Trials Act, 1987 — 1990 undertaken in this service.

In 2002, 10 patients were prescribed ECT in the Cavan unit. All the documentary procedures relating to this treatment were satisfactory.

The Inspectorate regarded easy access to fresh air a basic human need. However, this was a problem for some elderly residents in Carrickmacross and Castleblaney where both residences were located on the first floor. The Inspectorate noted the lack of educational, social and therapeutic activities for persons attending all of the community residences visited.

A specific member of staff should be assigned for the purpose of informing all patients, irrespective of their status, of their rights under the Mental Treatment Act, 1945. Voluntary patients should be informed that if they wish to leave hospital they must discuss this with their consultant psychiatrist or, in his or her absence, the clinical nurse manager. A record should be kept of the name of the person giving the information, the date the information was given, whether the patient understood the information, and, if not, a planned date for any subsequent attempts to give the appropriate information.

The Cavan/Monaghan management team recently conducted a review of service provision, which included a survey of the views of patients and their families, so that new objectives could be set and included in their operational plan. This review was in its final stages at the time of inspection and it was hoped a copy would be forwarded to the Inspectorate on completion.

All policies, procedures and guidelines, dated 1995 were under review at the time of inspection. An up-to-date central file of all current policies should be maintained. Each policy file should be indexed with responsibility identified for ensuring the file was updated and all superseded policies removed and a pre-determined number of copies retained centrally for future reference. Policies, procedures and guidelines should be formally introduced to all relevant staff ensuring awareness and understanding of content. Staff should sign that they had read and understood, intend to and are able to comply with policy content. The policy on patients absconding or absent from the unit should include information on who was to take charge of the procedure, how a local search is organised, map of grounds, when and who should contact the Gardaí and when and who should contact patient's relatives. The responsibility to return the patient to the hospital (if appropriate) should be clearly stated.

The Inspectorate was pleased to report that a programme of routine maintenance of community residences was on-going. Some re-decoration and refurbishment was required at the Valentia and Inishfree community residences on the grounds of St. Davnet's Hospital. There was evidence of smoking in bedrooms in both houses and this should be discouraged. Each community resident should be given a statement of the terms and conditions

of residency, to include the weekly scale of charges, with a system in place for reviewing and revising this periodically in partnership with the residents. There should be a care plan for daily living for each resident. Management should facilitate and encourage the involvement of community residents in all key aspects of their care.

All units visited were fitted with appropriate fire-fighting equipment and protected with automatic fire protection systems. All fire equipment should be inspected, at least annually, to ensure it operates effectively in emergencies and this should be dated and signed. Periodic evacuation drills should be conducted in all community residences and records kept.

The grounds and buildings at St. Davnet's Hospital were maintained in a satisfactory condition, with adequate external sign posting and facilities for the disabled.

Each newly-admitted patient to St. Davnet's Hospital had a full medical, psychiatric and social evaluation, documented in their case file. Written instructions on filing of documentation within the clinical record were available and the patient's name was clearly recorded on each continuation page. There was also provision on the assessment form for a detailed clinical risk assessment and management summary. However, not all sections of this form were completed in notes examined and no explanation was given for this.

Nursing records examined contained relevant information relating to the nursing observation of the patient and noted changes in the patient's condition, including progress made with nursing interventions for identified problems. Nursing documentation should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment. Entries should contain information about patients' wishes, preferences and suggestions about treatment approaches. Whilst all entries were accurately dated, time of entry should be recorded using the 24-hour clock. The biographical data sheet for each admission was recorded satisfactorily. A more robust system for recording of allergies/drug sensitivities should be introduced so that this information is rapidly available to all clinical staff.

The written policy for the ordering, prescribing, storing and administration of medicines was dated 1999. Prescriptions examined were signed and dated individually and the discontinuation column was completed satisfactorily for each drug discontinued. The drug administration-recording card had provision for the nurse's signature in full.

A number of patients at the Cavan unit were interviewed to ascertain their views on the level of service provision. All were satisfied with the courtesy and helpfulness of the staff and the hygiene and décor of the unit. One patient was four weeks in hospital and quite ill. This patient was actually a detained patient but, due to his illness, had not comprehended this and maintained he was of voluntary status. He was unaware of either his consultant psychiatrist or primary nurse or whether he had a care plan. He was informed of the nature of his psychological problems, as well as the effects and side effects of his medications but did not understand this. The second patient interviewed was an elderly lady of voluntary status, on her first admission. She felt she would have had a better

chance of recovery if treated at home. The third patient was a middle-aged man, on his third admission. He was very satisfied with his contact with the doctors and nurses. They were always available to him and he felt that they always treated him with respect and dignity. He was aware of the nature of his psychological condition and the medications had been fully explained to him.

One patient was very critical of the claustrophobic atmosphere of the unit; because the doors were constantly locked he felt he was in a prison. When asked what changes he would like to see in the unit he said that the locked door system should be abolished and better therapeutic activities, such as gymnasium facilities should be provided. He felt the unit was too “suffocating” for want of exercise.

RECOMMENDATIONS

It is recommended that:

1. The acute unit in St. Davnet’s Hospital close.
2. Efforts be made to source suitable community-based locations for some services currently inappropriately based in St. Davnet’s Hospital, as set out in the body of this report.
3. Sector headquarters and day hospitals be put in place in Carrickmacross, Monaghan town, Cavan town and in East Cavan.
4. A specialised service be established for the psychiatry of learning disability.
5. Formal written policies and procedures be agreed to ensure that the doors of the acute unit in Cavan be open as far as possible.
6. A review be carried out of the deployment of nursing staff to curtail overstaffing in some components of the service and divert personnel to more appropriate areas.

LOUTH MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 15 APRIL, 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 124,418 was divided into three sectors as follows:

Sector	Population
Mid-Louth East Meath	34,085
East North Louth	48,463
South Louth	41,870

The Louth Mental Health Service provided general adult psychiatric through a range of community-based services and in-patient services at St. Brigid’s Hospital.

IN-PATIENT CARE

St. Brigid's Hospital, Ardee, had 90 beds in one male, one female and two integrated wards.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	2	10	8	—	7	27	36.0
3-12 Months	—	—	4	1	5	1	11	14.6
1-5 Years	—	—	—	2	2	10	14	18.7
> 5 Years	—	—	2	7	3	11	23	30.7
All Lengths of Stay	—	2	16	18	10	29	75	100.0
% of Total	—	2.7	21.3	24.0	13.3	38.7	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
6	36	1	8	5	1
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
2	11	2	3	—	75

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	27	33	60
Temporary	3	3	6
P.U.M.	—	—	—
Ward of Court	3	4	7
Total	33	40	73

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
428	3.5	151	35.3	86.4	13.6	444	5

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	—	—	—
Day Centres	2	84	89
Out-patient clinics	5	199*	979

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
2	12	—	—	4	63

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
12	22	144	73	5

COST

The cost of the Louth Mental Health Service was €14.7 million in 2002

GENERAL COMMENTS

On this visit of inspection, the Inspectorate treated the Co. Louth service as an autonomous catchment area service. The Inspectorate was aware that the North-Eastern Health Board regarded this service as part of a wider joint catchment comprising Louth and Meath. The Inspectorate, however, was puzzled why this approach was taken, given that the three services of Louth, Meath and Cavan/Monaghan were of approximately equal population size.

An additional sector, based in Dundalk had been added to the Louth service. A consultant psychiatrist had been appointed, but after some delay had accepted another appointment elsewhere. This had slowed development. The newly-created post of consultant in later-life psychiatry had attracted no applicants and this post had been re-advertised. Funding for a consultant in rehabilitation had been provided. However, the Board felt that this funding was inadequate to recruit a full-time multi-disciplinary team. As there was no liaison consultant, this service was supplied to the Dundalk and Drogheda Hospitals by the sector consultants. There was also no specialised service for intellectually disabled people with mental illness. There was, however, the adjacent, but administratively and clinically separate service at Drumcar. There were few links between the two services.

The search for suitable premises in Dundalk to extend and consolidate the community-based service, including the provision of a day hospital, had been unsuccessful. It had also been hoped to acquire suitable premises in Drogheda for a sector headquarters, mental

health centre and day hospital. A similar move was required in Ardee for the mid-Louth sector. The high-support residence in Dundalk, An Solasán, was functioning well. However, as some of the residents were quite elderly, attempts should be made to re-locate them in accommodation for older people, in order to free-up places for some of the younger long-stay patients in St. Brigid's Hospital, Ardee. This situation also applied to the residents in the Point Road residence and, indeed, in St. Brigid's Hospital, where half of the patients were over sixty-five.

Unfortunately, the plan to convert the former RMS residence, Santa Barbara, for intensive care purposes had failed. The Health Board was now proposing to sell the property and surrounding land and to use the funds to provide a purpose-built facility for the region.

Some welcome initiatives had taken place, principally, the refurbishment of the admission ward, since the last visit of inspection. This renovation was in progress, despite the fact that the basic structure of the premises was unsuitable for modern acute treatment purposes. Once again, the Inspectorate pointed out the need for an acute admission unit in Louth County Hospital, Dundalk, to replace the admission unit in St. Brigid's Hospital. A project team had been established to advance this matter. All, but one, of the intellectually disabled persons had been transferred to the specialised Drumcar service. The Inspectorate understood that this patient would be transferred shortly. There were 73 patients in three wards, 30 of these being admission patients and the majority of the remainder being over sixty-five years. The remaining 40 patients, mostly long-stay older patients should be transferred to more appropriate accommodation to facilitate the closure of St. Brigid's Hospital. The Inspectorate noted that no suitable accommodation or treatment had been found for one patient on the admission ward who had, over the previous several months, been assaultive to patients and staff. This patient had been 'special-nursed' continuously over a twenty-four-hour period at considerable expense, both financially and in terms of scarce nursing staff and had caused the ward to be locked at all times. During renovation, the St. Brigid's service did not provide ECT and patients were transferred, with staff, to Our Lady's Hospital, Navan for treatment.

The Inspectorate formed the impression that admission decisions were not always made by consultants. Inspection of case notes indicated that intake appraisals, programme and treatment plans were not documented. There was also little evidence that the patient and family were involved as partners in planning treatment schedules. ICD diagnoses did not appear in clinical documentation and there was no evidence that patients were informed of their legal rights. Patients who had their period of temporary detention extended did not have this fact documented, nor the reason why it was deemed necessary.

The Inspectorate noted that the waiting list at the Ballsgrove clinic, Drogheda had been reduced considerably. Some of the out-patient clinics were unsatisfactory in relation to size and decoration.

There were 428 admissions to St. Brigid's Hospital in 2002, 50 of which were on temporary admission orders. In 2002, 26 of the involuntary temporary patients had their legal status re-graded during their period of hospitalisation; 16 patients admitted as voluntary patients

were re-graded to involuntary during their hospital stay. One patient was lodged overnight at St. Brigid's Hospital but was not formally admitted. In 2002, eight patients admitted to St. Brigid's Hospital were wards of court. Eighteen patients hospitalised on temporary admission orders had their involuntary detention orders extended during the year. There were 444 discharges and five deaths in 2002. During 2002, 17 patients took their own discharge against medical advice during the year and appropriate procedures were in place to follow-up if deemed clinically appropriate.

There were 17 recorded accidents to patients at St. Brigid's Hospital during 2002; six resulted in minor injury and three were deemed serious. Of the 12 recorded accidents to staff, two involved minor injuries and one was deemed serious. There were 11 recorded assaults on patients by other patients; five of which resulted in minor injury. Of the 32 recorded assaults on staff, 13 resulted in minor injury and two were deemed serious. The incident reporting system and the systems for recording, tracking and trending accidents and assaults at St. Brigid's Hospital was satisfactory.

Four patients were placed on special nursing supervision at St. Brigid's Hospital and there were 243 spans of special nursing supervision, involving duty spans of 12 hours or more in 2002. A written policy and procedure on special nursing was available for staff information. Reference records were kept of the length of time each staff member spent on special nursing supervision. The Inspectorate suggested that records should be kept of patients' own views on the process of special nursing supervision.

There were nine formal written complaints by patients or patients' representatives to the local complaints manager in 2002: 12 requests were made under the Freedom of Information Act, 1997 and all were dealt with satisfactorily, with the exception of one, which was ongoing at the time of inspection. A written complaints policy and procedure was available for the information of staff in the clinical areas of St. Brigid's Hospital. The comprehensive complaint policy and procedure, and the generic NEHB complaints procedure was dated November 1998. There were no research projects governed by the Clinical Trials Act, 1987 — 1990 undertaken in the Louth Mental Health Service. Information on patients' rights under the Mental Treatment Act, 1945 and amending legislation was prominently displayed in ward areas.

There were 260 liaison general adult psychiatric consultations at Our Lady of Lourdes Hospital, Drogheda, 372 at Louth General Hospital, Dundalk and a further 90 at St. Oliver's Nursing Home, Dundalk. Sixteen patients were admitted to St. Brigid's Hospital following consultation at Our Lady of Lourdes Hospital, Drogheda, and a further 61 were referred for out-patient treatment. Statistical information relating to the outcome of liaison consultations at Louth County Hospital and St. Oliver's Nursing Home, Dundalk was not available at the time of inspection.

It was noted that seclusion was not used at St. Brigid's Hospital in 2002 and there was no safe room available for that purpose. However, a new room was under construction in the refurbishment of the admission unit. The Inspectorate welcomed the new physical intervention and restraint policy and the on-going training for all staff on the management

and control of aggression and violence. The policy on physical restraint emphasised that all initial attempts to restrain aggressive behaviour should, as far as the situation allowed, be non-physical. Where physical restraint was used, it should only be used as a last resort when all other interventions had failed, and used for the protection of the patient, other patients or staff members. A special physical restraint report form was in use, with the name of the patient, reason for restraint, brief description of intervention, staff members involved and review of the situation by a medical officer. The Inspectorate reviewed some of these documents in the course of this inspection. A physical restraint report form had corresponding detailed entries in the medical and nursing notes relating to the incident where staff were obliged to physically restrain a patient. The standard of completion of the physical restraint report form was variable; some forms were well completed. It was noted that the third section, relating to the review by the doctor, time of review, post-incident review and signature of team leader and assistant director of nursing were not completed on a number of forms examined and no reason or explanation was given for this. However, the Inspectorate welcomed the introduction of the policy and the innovative restraint report form and would recommend similar systems in all other services.

As on previous inspections, it was noted that all three wards in St. Brigid's Hospital were locked. The service management should ensure that clear service-wide policies on the locking of external ward doors exist and that compliance was regularly audited. The principle of the least restrictive form of care should at all times be applied, especially in all wards accommodating voluntary patients. The Inspectorate recognised that staff were responsible for the care and protection of patients and maintenance of a safe and secure environment. However, the locking of doors should never impede the free movement of patients whose clinical needs did not warrant such restrictions.

Since the previous inspection, a comprehensive policy on the administration of medical preparation, a revised medication sheet, prescription card, drug-recording card, with directions for use, had been introduced in this service and appeared to be working well. All prescriptions were dated individually, as was the discontinuation column. A number of prescriptions required the signature, in full, of the prescriber. The drug administration-recording card should have provision for the nurse's signature in full when this card was next reprinted. Alternatively, a record should be kept in the local clinical areas of the nurse's signature in full and sample initials, to enable easy identification of the nurse in the future. There was provision for the recording of drug allergy or drug sensitivity on the prescription cards. However, this section was not completed. If there were no known drug sensitivity or drug allergies this should be recorded. All other policies, procedures and guidelines in this service were under review and would be introduced on a phased basis.

A generic health board safety statement and a site-specific safety statement for the hospital and local units, adhering to the standards and procedures set by the Safety and Welfare at Work Act, 1989 was available. There was a safety committee at the hospital, incorporating the fire committee, which met a month prior to the inspection, and appropriate minutes of meetings were kept. Environmental safety audits had been conducted with adequate training courses for staff in fire precaution techniques and evacuation procedures in all residential settings. The checking and inspection of equipment, to ensure it worked

in emergencies, appeared satisfactory. Fire exits were clearly marked and fire orders prominently displayed in all areas visited. A panic alarm system was provided for units with a particular risk of violence, with a system in place for checking the effectiveness of this alarm. Also a written policy for the use of this panic alarm system was provided.

All food preparation areas had been audited recently to ensure compliance with modern food and hygiene standards. Some remedial work was required and this was now underway. The physical environment of the dining areas and the quality of food and tableware were satisfactory, with patients given a reasonable choice and meals provided at socially acceptable times. Appropriate hygiene training was provided for all catering staff.

A number of clinical files were examined during this inspection. Written instructions for the filing of documentation within the record were required. While there was provision for the recording of the patients' name on each continuation page of the clinical file, this was not always recorded. Each newly-admitted patient had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and clear immediate management plan appropriately recorded and dated in the notes. However, it was recommended that the time of entry should be recorded; the person making the entry should sign their name in full and record their designation within the multi-disciplinary team.

There was a comprehensive policy on patients absent from the hospital without official leave, outlining the areas of staff responsibility, how local searches were organised and who should contact the Gardai and the patients' relatives. It was noted that, while illicit drug or drug-related incidents were not a major feature of the service, there was a need to issue guidance on the management of illicit drug use and drug-related incident, setting out the action to be taken by staff members if there was a suspicion of illicit drug use or supply within the hospital. There was also need for a policy for staff to search and confiscate illicit drugs, alcohol or dangerous weapons and highlighting the arrangements with the Gardai for the disposal of these items.

The 'Roper' model of nursing involving an appropriate care planning system was used throughout St. Brigid's Hospital. Care plans were recorded in a separate booklet, which was secured to the medical folder post-discharge. The nursing care-plan booklet comprised historical and personal data, assessment details and evaluation progress notes, a pressure-sore prevention risk assessment and protection chart and nursing dependence level chart. Care plans were reviewed weekly. Incorporated into the nursing care plan was a detailed admission and discharge checklist and an appropriate sleep chart was recorded for each patient post-admission. All of this was most satisfactory. All entries were accurately dated. However, the time of entry was not always recorded. This should be recorded, using the 24-hour clock. Consideration should be given to the recording in the nursing assessment of a physical description of the patient, hair colour, height etc. The nursing evaluation progress report should reflect the involvement of patients in planning and making choices and decisions about their care and treatment. It should include patients' wishes, preferences and suggestions about treatment approaches. Similarly, nursing evaluations should include patients' view about progress.

This service had a written policy, philosophy and model of care for each component of service provision, which was brought to the attention of patients and visitors, through the information leaflet. The service providers should consider producing an annual written report highlighting achievements, strengths and weaknesses in service provision during the year and outlining goals for the coming year. This should be done as part of an evaluation process, which systematically assesses relevance, adequacy, progress, efficiency, effectiveness and impact of service provision. Quality assurance activities conducted both internally and externally ensure that clinical and service goals and objectives are met in addition to the review of policies and procedures on a regular basis. Internal audits of record-keeping standards, medication and prescribing patterns and other matters relevant to the care of patients should be undertaken periodically.

Notices on patients' rights were prominently displayed in the admission unit along with a comprehensive, attractively presented, information leaflet containing information pertinent to a patient's stay in hospital. The Inspectorate suggested that service providers should consider the introduction of a standardised form to record that information has been given to patients about their legal position and rights under the Mental Treatment Act, 1945. This form should include the name of the person giving the information, the date the information was given, whether the patient understood the information, subsequent attempts to give the information and a planned date for the next attempt. The Inspectorate recognised that there may be difficulties in explaining legal matters to some patients whose mental state may preclude the understanding or retention of such information. However, it was necessary to ensure that information on patients' rights was given in a way that the patient understands and a record of this should be kept in the patients' case notes.

A number of patients were interviewed to ascertain their views on the level of care provided. Patients were satisfied with the courtesy and helpfulness of staff. However, two patients indicated that they did not have an assigned primary nurse. The majority of the patients had received written information relating to their treatment. Some patients complained of inadequate laundry facilities and secure storage facilities for clothing and personal possessions. Some patients felt there was no easy access to the open air, making the atmosphere confining. One patient expressed concern about the cleanliness of the toilets and bathrooms.

RECOMMENDATIONS

It is recommended that:

1. The Louth and Meath services be separated, both administratively and clinically or alternatively be incorporated into a regional service for the entire Board area.
2. Plans to progress the provision of an Acute Admission Unit at Louth General Hospital, Dundalk, be vigorously pursued.
3. The quest to acquire premises and personnel for the extension of multi-disciplinary community-based services be intensified.

4. A comprehensive day hospital/sector headquarters/community mental health centre be established for each sector.

MEATH MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 20 MAY, 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 109,250 was divided into three sectors as follows:

Sector	Population
Navan	35,769
Dunshaughlin	35,497
Kells/Trim	37,984

The Meath mental health service provided general adult psychiatric and specialist later-life psychiatric services through a limited range of community-based services and in-patient services at Our Lady's Hospital, Navan.

IN-PATIENT CARE

Our Lady's Hospital, Navan had 26 beds in one integrated unit.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	9	9	—	—	18	81.8
3-12 Months	—	1	3	—	—	—	4	18.2
1-5 Years	—	—	—	—	—	—	—	—
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	1	12	9	—	—	22	100.0
% of Total	—	4.5	54.5	41	—	—	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	7	1	8	4	2
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
—	—	—	—	—	22

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	11	9	20
Temporary	2	1	3
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	13	10	23

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
277	2.5	67	24.2	89.2	10.8	283	0

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	—	—	—
Day Centres	3	55	91
Out-patient clinics	4	309*	814

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
—	—	1	6	1	12

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
11	6	55	8	7

COST

The cost of the Meath Mental Health Service was €2.8 million in 2002.

GENERAL COMMENTS

In the North-Eastern Health Board area there were three mental health services of equal population size, Cavan/Monaghan, Louth and Meath. It appeared that the Meath service had not yet attained independent status as a catchment area service, with the Director of Nursing and the Clinical Director of the Meath service being those of the Louth service.

The Inspectorate noted one new event since the previous inspection. The psychiatry of later-life service had been established, with a consultant, a nurse, a social worker and NCHD. This team was to be provided with a day hospital at Kennedy Road, Navan, but learnt, apparently for the first time at the meeting with the Inspectorate, that the premises might have to be shared with a proposed home-care initiative for the Navan sector. The fact that this had only emerged at this meeting exemplified the communication and planning difficulties that bedevilled the Meath service. This was caused, to a large extent, by the fact that the Meath service was managed from Louth. The later-life service did not have a separate sub-unit for acute assessment purposes in Our Lady's Hospital, Navan. There was also concern about continuing-care facilities for this service.

There were still serious deficits in the provision of community services in Meath. There was no day hospital in the entire service. Clonard House in Navan had become a sector headquarters for the Navan sector. However, apart from two out-patient clinics per week — which would be better located in a primary-care setting — there was no patient presence. The aspiration to procure an alternative site and building for the Táin day-centre had not yet materialised. In Kells, no premises had yet become available for residential purposes or as a replacement for the Newmarket house. Plans to enlarge the Dunshaughlin day facility remained static. Overall, the Meath Mental Health service was a long way from providing a day hospital and mental health centre in all of its three sectors. Further recruitment was necessary to strengthen the sector teams, from a multi-disciplinary point of view — there was, for example, no Occupational Therapist in the service.

The in-patient unit at Our Lady's Hospital, Navan, was pleasant and attractive but it suffered from a lack of space for occupational or recreational activities. While the unit coped well with the demand for in-patient beds, there were occasions when none were available and recourse had to be had to the admission unit at St. Brigid's Hospital, Ardee. However, due to the low admission rate in the service and, in spite of the virtual absence of community services, the number of such transfers in 2002 was only twenty. The Inspectorate was also informed that patients presenting came directly to the unit rather, than as had been advised, through A&E.

The Inspectorate was happy to learn that a home-care approach was being contemplated in the Meath service. However, the limited human resources available to the service would need strengthening if this was to be achieved.

There were 30 involuntary admissions to the Meath mental health service in 2002. One patient had a temporary admission order extended during the year; nine had their admission status re-graded to voluntary during the course of their hospital stay. In 2002, 25 patients were re-graded to involuntary status during the course of their hospitalisation. Twenty patients were transferred from Our Lady's Hospital, Navan to St. Brigid's Hospital, Ardee in 2002. There were 253 general adult psychiatric liaison consultations at Our Lady's Hospital, Navan, resulting in 16 admissions to the psychiatric unit and 71 referrals to the psychiatric out-patient department.

There were 93 episodes of seclusion, involving 16 patients, at the Department of Psychiatry, Our Lady's Hospital, Navan. The Inspectorate recommended that medical staff authorising seclusion should use their full signature and designation and that patients should have an unrestricted view of a clock in the secluded area. There were 554 spans of special nursing in 2002, including nine patients on one-to-one nursing. Six patients were prescribed ECT in 2002. There was a tri-partite ECT suite, with guidelines for the administration of ECT prominently displayed in the treatment area. Information leaflets, including information about the risks of ECT and availability of alternative treatments, should be developed to enable patients and their family to make an informed decision regarding the appropriateness of this treatment. All documentary procedures, policies, protocols, consent forms, pre- and post- ECT checklists were regularly revised and updated as part of the Q mark award procedures at Our Lady's Hospital. It was noted that clinical status was assessed following each ECT session, which was very satisfactory. The detailed physical examination of the patient prior to ECT was appropriately recorded in the medical notes.

There were 24 accidents to patients; five were deemed serious and 11 accidents to staff at Our Lady's Hospital, Navan in 2002. There were three assaults on patients by other patients, one resulting in minor injury and eight assaults on staff, three resulting in minor injury and one deemed serious. There was ongoing staff training on the management of aggression and violence, cardio pulmonary resuscitation, safe lifting etc. The Louth/Meath area had its own team of trainers. New staff should be asked to sign a document stating that they had received formal induction training.

There were no formal complaints by patients or patients' relatives during 2002 and there were no requests under the Freedom of Information Act, 1997. There were no research projects governed by the Clinical Trials Act, 1987-1990 undertaken in the Meath mental health service. Information on patients' rights under the Mental Treatment Act, 1945 and amending legislation was prominently displayed.

All policies, procedures and guidelines were under review. Each policy and guideline should have a reference number; state the authors, policy application and purpose. References used should be clearly stated and the date of approval and by whom clearly recorded.

The corporate risk management policy/strategy dated November 2001 was available in the Unit. A detailed safety audit was conducted in January 2002 identifying hazards and recommended remedies, where appropriate. The location safety statement was unsigned by the department head and the name of the person responsible for executing the safety management programme was not stated. There was a joint fire and safety committee for the Meath/Louth mental health service.

The quality and choice of food was very satisfactory, with a printed daily menu available and meals provided at socially acceptable times. The standard of cleanliness of the dining and kitchen areas was also satisfactory. Ideally, the dining area should be separate from the recreational area.

The grounds and buildings at Our Lady's Hospital, Navan and at the Dunshaughlin health care unit were of a high standard with appropriate internal and external sign posting and adequate facilities were available for the disabled. All premises had written fire orders and the checking system to ensure emergency equipment operated when needed was satisfactory. Patients had free and easy access to the hospital shop. All staff in the service wore an identifying badge stating their name and designation within the multi-disciplinary team.

A three-year strategic plan, rolled forward on an annual basis, on how the service objectives are to be met would be beneficial to this service. Also, an annual report highlighting the strengths and weaknesses of service provision and linked to service objectives and targets should be produced. A system of clinical audit, risk assessment and patient and family user satisfaction surveys should be introduced to inform this process.

A number of medical files were examined and found to be of moderate quality. The full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and clear immediate management plans were all clearly documented in notes examined. Ideally, a doctor should write their name, sign the entry and record their designation to ensure easier identification of the practitioner in the future. It was also noted that there was storage of loose clinical material within the file. Risks associated with this included lost or misfiled information or delays in accessing pertinent information. User friendly written information on prescribed medication should be readily available to all patients and relatives.

Nursing records using the 'Roper model' of nursing were appropriately recorded. The up-to-date biographical data sheet for each admission contained completed records of the patient's legal status, next-of-kin, and general practitioner. There was provision for recording drug allergies and drug sensitivities. However, this section was left blank in a number of notes examined and no reason was stated. Time of entry should be recorded using the 24-hour clock. A written policy on the use of abbreviations was required as a number of abbreviations were noted in the nursing notes. In one folder under the heading "maintaining a safe environment" the records stated a patient "feels suicidal" and the appropriate care plan stated "maintain safety". No explanation was given as to what this meant and there was no further mention of it in the progress report, therefore, it was not possible from an examination of the notes to determine what issues had been considered.

There was a written policy for the ordering, prescribing, storing and administration of medicines, which was undated. New prescription cards had been introduced to the service. Prescriptions were signed and dated individually, with one signature and one date for each prescription and discontinuation columns completed satisfactorily. The Clozaril service remained centralised in Navan rather than being based in the sectors. Written guidelines on the administration of clozapine were available for staff information and reference. Three patients, two males and one female, randomly selected, were interviewed in order to determine their level of satisfaction with the care provided. Two patients were voluntary and one was of temporary status. All had previous hospital admissions, though not necessarily to the Navan Unit. All were satisfied with the courtesy and helpfulness of staff, were introduced to the professional team responsible for their care, and knew the name of their

consultant psychiatrists. They were particularly pleased with the frequency of consultation with their consultant psychiatrists and the ease of accessibility to them. All were pleased with having the 'Primary Nurse System' in operation and they felt fully involved in their caring process. A social worker was involved with one patient and a psychologist with another and their inputs were greatly appreciated. All three were aware of their rights' under the Mental Treatment Act, 1945 and when asked about the complaints procedure all three stated that they had nothing to complain about. They had received a hospital booklet containing relevant information regarding their illnesses, medications and their side effects; this they found very useful. However, one patient expressed the desire to have information on prescribed medication in written form. Patients indicated that they would like greater privacy to speak with family and visitors. Some patients reported that they would like more, and better organised, indoor and out-door activities.

RECOMMENDATIONS

It is recommended that:

1. The Meath Mental Health service be administered autonomously and independently from the Louth Mental Health service or incorporated into a regional service for the entire Board area.
2. The community services, physical and human resources, be augmented to enable comprehensive community care to be delivered.

CHAPTER SIX

North-Western Health Board

DONEGAL MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 27 MAY 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 129,008 was divided into six sectors as follows:

Sector	Population
Donegal Central	22,743
Donegal North Central	15,697
Donegal South Central	21,191
Donegal North East	28,956
Donegal North West	22,866
Donegal South West	17,555

The Donegal Mental Health Service provided adult psychiatric care and specialist later-life care through a range of community services and the psychiatric unit at Letterkenny General Hospital.

IN-PATIENT CARE

In-patient care was provided at the acute psychiatric unit at Letterkenny General Hospital, which had 54 beds, and at St. Conal's Hospital, which had 42 beds.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	19	10	2	1	33	44.6
3-12 Months	—	—	5	1	3	—	9	12.2
1-5 Years	—	—	5	6	1	—	12	16.2
> 5 Years	—	—	1	15	4	—	20	27.0
All Lengths of Stay	—	1	30	32	10	1	74	100
% of Total	—	1.4	40.5	43.2	13.5	1.4	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	31	—	14	5	4
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
5	6	1	8	—	74

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	35	30	65
Temporary	6	3	9
P.U.M.	1	1	2
Ward of Court	—	—	—
Total	42	34	76

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
780	6.1	226	29.0	88.2	11.8	792	1

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	20	202
Day Centres	7	141	319
Out-patient clinics	14	544*	1,414

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
12	55	0	0	4	67

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
11	18	181.5	72.3	7.2

COST

The cost of the Donegal Mental Health Service was €18 million in 2002.

GENERAL COMMENTS

There were two major outstanding issues confronting this service which were no nearer resolution than at the time of the last visit of inspection. The first was the adaptation and re-modelling of the acute unit at Letterkenny General Hospital for modern practice and patient care and the second, and interrelated, was the vacation of the three wards which remained open in St. Conal's Hospital. Plans had been drawn up to provide a forty-bedded

unit with accommodation for acute later life and close observation sub-units. These had been submitted to the Hospital Planning Office of the Department of Health and Children but there seemed to be some questions raised about the suitability of the design and, of course, there was also the question as to whether the capital monies were available to proceed even if the design was agreed. Friends of Letterkenny Hospital were actively fund raising for the proposed unit and intended to raise considerable monies.

With regard to the closure of the three St. Conal's Wards, the elderly patients in the de-designated St. Agnes Ward had nursing home places reserved for them. The Inspectorate understood that these places were currently being paid for and that the two houses were ready for the reception of the majority of patients from St. Bernadette's and St. Ciaran's wards. On vacation of these wards, the plan was to move the admission wards to this location in St. Conal's while the admission unit was being re-modelled. However, these proposals were subject to negotiations with the nursing unions, and the Inspectorate had the impression that this matter was not being dealt with expeditiously. Meanwhile, the patients lost out; an unacceptable situation. The out-patient accommodation, as in the current acute unit, will not be incorporated in the new layout, which is as it should be, as this function should take place in a primary care setting. Given that the move back to St. Conal's of the admission facility on a temporary basis is retrograde, the Inspectorate can only hope that the re-modelling will be completed in as short a time as possible.

There were six sectors in the Donegal service and the aspiration should be to make these all self-sufficient with mental health centres/sector headquarters and day facilities. This was far from being the case, although there were rudimentary resources of this kind in Donegal Town and Dungloe. However, in the one location where this was currently possible — at Park View House, Letterkenny — instead of using the premises as a sector headquarters/mental health centre and acute day hospital the premises was ill-defined in role and function and was clearly not being used to optimal purpose and was certainly not functioning as an acute day hospital.

The Later-life service was now operational and consultant-led, had recruited a complement of nurses but had no psychologist, social worker or occupational therapist. Neither had it an acute assessment sub-unit, and only very speculative assess to continuing care. It had an out-of-town location, which might prove difficult to access for patients without transport. There was a consultant for intellectual disability in the county but this service was free standing and not integrated into the mental health services of the catchment area; this needed to be remedied. The Work-Link programme in the county was impressive but this should function as a component of a specialised rehabilitation team with a consultant and team recruited for this purpose. The cognitive behaviour and family therapy teams were dismembered from the rest of the psychiatric programme and should be integrated into the sector teams and work with them in an accountable and integrated fashion. The Inspectorate welcomed the opening of the new community residence in Dungloe.

In 2002, 91 patients were admitted to the Acute Unit, Letterkenny General Hospital on temporary admission orders and one patient was admitted as a ward of court. During

2002, 11 patients in the Donegal Mental Health Service had their temporary admission orders extended; 29 patients admitted as voluntary patients were re-graded to involuntary status, 23 patients admitted on temporary admission orders were re-graded to voluntary in the course of their in-patient treatment. In 2002, 70 patients took their own discharge from the acute unit at Letterkenny General Hospital against medical advice — a reduction from 93 the previous year. Procedures were in place to follow-up these patients if deemed clinically appropriate. Three patients became new long stay patients in 2002 and all were aged under sixty-five years.

There were four complaints made by patients or their relatives to the local complaints manager in 2002. In addition, there were 37 requests for information under the Freedom of Information Act, 1997. All requests appeared to have been dealt with satisfactorily. There were no research projects governed by the Clinical Trials Act, 1987-1990 undertaken in this service in the year 2002.

Seclusion was not used in the Donegal mental health service. In 2002, 35 patients were placed on special one-nurse-to-one-patient supervision and there were 787 duty spans of special nursing supervision involving periods of ten hours or more. ECT treatment was prescribed for 14 patients in 2002. There was a dedicated ECT suite comprising a treatment and recovery room. A named consultant psychiatrist was responsible for the ECT clinic and the induction of all junior doctors. The consent form for ECT was satisfactory.

Forty-three accidents to patients resulted in no detectable injury, 25 caused minor injury and one accident was deemed serious. There were three accidents to staff resulting in minor injury during 2002. There were 22 recorded assaults on patients by other patients, seven resulted in minor injury such as scratches or bruising and one was deemed serious. There were 50 recorded assaults on staff, two were deemed serious and 11 resulted in minor injury.

The majority of policies and procedures were over two years old and many did not have review dates. Joint working policies, protocols and standards should be developed and reviewed on a multi-disciplinary basis yearly. All policies, procedures, protocols and guidelines should have a policy reference number, name of author, statement of purpose of the policy and its application. Each policy, protocol or guideline should be headed with the hospital title, be individually numbered, the date of ratification should be recorded and by whom ratified and a computerised index of all policies should be kept. Revised and superseded policies should be removed with a certain number kept in a central file for future reference.

Revised safety statements should be introduced to relevant staff who should be asked to sign a document stating that they have read and understood its content.

A key indication of a quality assurance programme involves management regularly reviewing different aspects of service provision and providing feedback to staff about performance so that new objectives can be set. The Inspectorate was pleased to note that an audit of medication and prescribing patterns was underway at the time of inspection.

Following on from this, there was a need for an audit of record-keeping and nursing records to assess standards and identify areas for improvement and staff development. As recipients of health service provision patients' views were recognised as a valuable reference tool when providing and evaluating services. The North-Western Health Board had taken very positive steps to ensure that the views of patients were taken seriously. A system of seeking the views of patients at the time of their discharge should be introduced as part of a quality assurance programme. Asking people for their opinions will raise expectations that those views will be acted upon. This may not always be possible, for example, because of financial constraints. A clear explanation of any constraints on action should therefore be given when people's views are sought.

A Mental Health Day for carers and users of the mental health service was organised in Letterkenny in March 2002 at which 35 people attended from Grow, Mountsouthwell Social Club, Buncrana and Inishowen Carers' Group and Healthy Women Healthy Voices Certificates Course. The Inspectorate welcomed the initiative of the Donegal Mental Health Service to involve service users and carers in this formal and positive way. A comprehensive report from the day's activities was forwarded to the North-Western Health Board. The group felt that the building of the admission unit at the General Hospital, Letterkenny had been a big step forward and saw the relocation, even on a temporary basis, of this unit back to St. Conal's as a retrograde step. The group suggested that the site originally chosen for a new admission unit was too far removed from the general hospital. It could result in isolation or rejection or a difference being made between physical and mental illness in the public mind, adding to the stigma so often associated with mental illness. The group set out what they believed would be required in a refurbished or new admission unit.

A number of clinical files were examined. There were written instructions on filing of documentation within the record on the file cover. Whilst there was provision for the recording of the patient's name on each continuation page this was not always recorded. Each newly-admitted patient had a full medical evaluation including comprehensive admission notes, mental state examination, physical examination and clear immediate management plan appropriately recorded in the notes. The typed clinical notes setting out a summary of admission details were of a high standard. Discharge summaries examined were typed and of a high standard. The storage of loose clinical material within the medical files should be reviewed to minimise the risk of delays in accessing pertinent information or loss of important clinical information. The section in the front of the medical file for recording adverse reactions to prescribed medication/allergies was not completed in most files examined. If there were no known drug sensitivities/allergies this should be recorded. Each entry was dated but the individual's name in print and their job title should accompany each signature.

The service had a written policy on patients absent without official leave. This policy indicated when the patient should be regarded as absent without official leave. The policy should also state who should take charge of the absent without official leave procedure and how they should determine who should undertake a local search and the extent of the local search, when a wider search should be undertaken and by whom and what area

should be searched. A map of the grounds of both hospitals should be available for this purpose. The policy should also state the name of the person with responsibility for contacting the gardaí and the name of the person with responsibility for contacting the patient's relatives.

There was a written complaints procedure on public display in the admission units but it was unclear if this was ever brought to the attention of patients. There was no notice on patients' rights under the Mental Treatment Act, 1945 and amending legislation displayed in the admission unit. All patients, irrespective of their status, should be informed of their rights. Voluntary patients should be advised that if they wish to leave hospital they should discuss this with their consultant psychiatrist or in his or her absence, the clinical nurse manager. Upon admission, or as soon as practicable thereafter, patients must be informed of their rights. Ideally, this information should be given in writing (by handing a rights leaflet or hospital brochure to the patient) with a verbal explanation of its content. An entry should be made in the nursing documentation that an oral and written explanation had been given to the patient with an indication of the patient's understanding. If the patient was clearly incapable of understanding, this should be recorded and the information should be repeated at regular intervals. The Inspectorate recognised the difficulty in explaining legal matters to patients whose mental state may preclude the understanding or retention of such information. It was therefore important that services be sensitive to the capacity of each individual patient and use professional judgement to ensure rights are explained as far as possible in a manner that the patient understands.

Patients at the acute unit, Letterkenny General Hospital had access to the shop on the hospital campus. Users and carers indicated in their report that going to the coffee dock with a family member had become a part of their recovery process and reintegration into the community. They also noted that the coffee dock and shop in the general hospital offered a valuable way forward into workplace employment.

Nursing documentation examined had a correlation between the self-care deficits, nursing goal, nursing care plan and notes. Generally the nursing documentation contained relevant information relating to the observation of the patient and changes in the patient's condition. An entry was made in the documentation relating to how well a patient settled into the ward after their first day of hospitalisation. The biographical data sheet for each admission was generally well recorded. Nursing records should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment. Evaluations of the nursing care plan should include patient's views about progress.

The written policy for ordering, prescribing, storing and administration of medicines was dated 1999. This policy manual was not available in St. Bernadette's Ward; however, the overall legibility of individual prescriptions in this ward was of a high standard. The prescription cards and drug recording system in the Donegal Mental Health Service was under review at the time of the inspection. All written prescriptions should contain the signature in full of the prescriber to enable future identification of the practitioner. The drug administration-recording card should have provision for a nurse's full signature.

Three patients were interviewed to ascertain their opinions on the psychiatric services provided. All three were of voluntary status and all had previous admissions. One patient had a prior admission ten years ago, had just spent four weeks in hospital on this occasion, and was due to be discharged that evening. Her delight at being allowed home appeared to be reflected in her opinion of the hospital and its services. She had no criticism of the hospital or staff and neither would she volunteer an opinion as to how the services could be improved. The other two patients were not so positive in their responses. While they were always treated with courtesy and respect they hadn't a good impression of the Unit generally. It was too overcrowded and noisy and they found it difficult to relax there. One was very pleased with the treatment and care received from the nurses and doctors, especially with the privacy and frequency of medical consultations. The second patient was not too happy in this regard, saying the staff were too busy to have sufficient time for the patients. However, the negativity generally expressed by this patient was due to an obvious underlying depression. None of the patients were aware of nursing care plans and neither was aware if any specific nurse was primarily responsible for their care. Two of the patients were not aware of their rights under the Mental Treatment Act, 1945 and neither were they aware of any complaint procedure being in place. The only suggestion they made for the improvement of the service was to remedy the overcrowding situation and to have more varied recreational activities.

RECOMMENDATIONS

It is recommended that:

1. The three wards in St. Conal's Hospital be vacated as quickly as possible and the patients be relocated to the residential and nursing home accommodation procured for them.
2. The remodelling of the acute unit in Letterkenny general hospital commence immediately.
3. The Letterkenny day centre relocate from its current premises in the former St. Eunan's ward to the part of St. Conal's currently occupied by the educational services.
4. The physical and human resources essential to enable a comprehensive sector-based day and outreach domiciliary service delivery to take place in all sectors be put in place.

SLIGO/LEITRIM MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 28 MAY, 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 89,648 was divided into five sectors as follows:

Sector	Population
Sligo City	27,933
West & North Leitrim	15,324
North Sligo, and South Donegal	13,533
South Sligo	14,322
South Leitrim West Cavan assimilated	18,536

The Sligo Mental Health Service provided general adult psychiatric care through a range of community services, in-patient care at Ballytivnan and specialist services for the elderly

IN-PATIENT CARE

The Mental Health Service at Ballytivnan, Sligo, which had 54 beds in one male, one female and one integrated ward, provided in-patient care.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	14	10	6	1	31	64.6
3-12 Months	—	1	6	7	—	—	14	29.1
1-5 Years	—	—	1	1	—	—	2	4.2
> 5 Years	—	—	—	—	1	—	1	2.1
All Lengths of Stay	—	1	21	18	7	1	48	100
% of Total	—	2.1	43.7	37.5	14.6	2.1	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	20	3	7	1	2
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
3	2	—	1	9	48

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	17	17	34
Temporary	8	6	14
P.U.M.	3	1	4
Ward of Court	—	—	—
Total	28	24	52

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
532	5.9	104	19.5	88	12	537	1

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	30	119
Day Centres	7	177	225
Out-patient clinics	12	347*	3,105

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
14	58	2	11	8	104

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
18	21	246	45.5	19

COST

The cost of the Sligo/Leitrim Mental Health Service was €20.6 million in 2002.

GENERAL COMMENTS

The Sligo/Leitrim Mental Health Service now had five sectors for the delivery of general adult psychiatric care and a specialised service for the elderly. There was a child and adolescent service as part of the Community Care Programme and not of the Mental Health Service Programme.

The acute psychiatric unit for Sligo General Hospital was planned, designed, and agreed with the Department of Health and Children and signed off in 1992. However, nothing had happened since and this, apparently, had been the consequence of consultants requesting that there be a second-storey added to the building to accommodate offices and to provide an administrative centre. This had resulted in altered plans and much discussion between the Board and the Hospital Planning Office in the Department. Funding required to build the unit, which was available in 1992 may not now be immediately available. There were cogent reasons why this alteration was unnecessary. Apart altogether from cost, perfectly adequate and appropriate office accommodation was available in the educational centre, with the nursing administration located a few yards away. Policy also dictated that the administrative catchment area be based physically separate from acute in-patient services, which must be located in a general hospital setting, whereas administration was, of course, concerned with the entire service and not just the in-patient unit.

Having considered the geographic disposition of catchment areas and their populations, the Inspectorate would propose mental health centres/sector headquarters and day hospitals in the following locations:

- A premises in Cliffoney to serve North Sligo and South Donegal with the retention of the on-going day centre at the Sheil Hospital at Ballyshannon.
- The Markievicz house premises in Sligo town should serve as the sector headquarters/mental health centre and acute day hospital for Sligo town and be staffed by one consultant-led multi-disciplinary team working out of the premises, rather than the current illogical arrangement pertaining to its current usage.
- West Sligo required a sector headquarters and day facility at Easkey in conjunction with the primary care facility in that town.
- North Leitrim required a similar development at Manorhamilton.
- Finally, in south Leitrim, the new and extensive health care initiative proposed for Carrick-on-Shannon should incorporate the acute day hospital and mental health centre/sector headquarters for that sector.

These proposed developments in the sectors as outlined above should incorporate an outreach and home care components. There should be little difficulty in accomplishing this, given that there were one-quarter more nurses in the service than in the Cavan/Monaghan service where this manner of service delivery existed. It was noted that Sligo/Leitrim was an expensive service per head of population, largely because of the high number of nursing staff employed. In fact, there were many instances of overstaffing in the service, particularly in the community residences. Ironically, there was not one psychologist, although the North-Western Health Board had advertised a post which they were unable to fill. Those working as family therapists and as cognitive behavioural therapists should become members of multi-disciplinary teams and not operate as independent individuals. A comprehensive planning and management group should be established for the purpose of realising these objectives.

The later-life service was under-resourced, without acute assessment facilities of an appropriate nature and with very limited continuing care beds, although it was stated that the existing Alzheimer unit at St. John's Hospital would be transferred to this service. There was no psychologist in this team and the social work service was understaffed similar to the general adult service. Arrangements were being made to lease an attractive house in its own grounds at Pearse Road on the southern outskirts of Sligo town to serve as the headquarters of this service and to provide a day service. Steps were advanced to recruit consultant-led teams for rehabilitation psychiatry and the psychiatry of intellectual disability. The intellectual disability service was attached to the Community Care Services of the North-Western Health Board.

The Sligo day centre, Raheen, at Nazareth House was quite unsatisfactory — too small, but there were plans to relocate and enlarge it. The house at Manorhamilton that had lain idle for some time was shortly to be the subject of further renovation. Meanwhile, the Summerhill premises at Carrick-on-Shannon still had difficulty with water penetration. The hope was that new premises would become available in the planned extensive health care development on the campus. The attractive building and grounds in Mohill were to be retained, despite costly difficulties with the roof. Careful thought should be given to the future of the Special Care unit at Ballytivnan particularly in the context of the rehabilitation team; discussions should take place in consultation with the Donegal service, which currently had five long-stay patients in the unit.

The up-grading of the out-patient facilities at Manorhamilton was welcomed. The out-patient facilities at Kinlough required refurbishment and the installation of an improved heating system. There was a need for the refurbishment and the re-decoration of the Ballyshannon out-patient clinic. Conditions at the Ballymote and Tubbercurry out-patient facilities were cramped due to lack of space.

There were 64 involuntary admissions to the Sligo Mental Health Services in 2002: 24 of these were PUM admissions and 40 were on temporary orders. In 2002, 29 patients admitted as involuntary patients were re-graded to voluntary status and 15 patients admitted as voluntary patients were re-graded to involuntary status during the course of their hospitalisation. Ten patients had their temporary admission orders extended. There was one death in the Ballytivnan Unit, Sligo and the result of the inquest was awaited.

There were 17 episodes of serious self-harm in the hospital and all appeared to have been dealt with satisfactorily. There were 98 recorded accidents to patients and five recorded accidents to staff: 17 accidents resulted in minor injury. There were 50 recorded assaults on patients by other patients; five resulted in minor injury. Of the 110 recorded assaults on staff, six resulted in minor injury and none were deemed serious. The administration system for recording of accidents, incidents and assaults was satisfactory. In view of the increase in accidents and assaults, a rolling audit programme should be developed on all non-clinical and clinical incidents with a view to developing a system for tracking and trending all adverse incidents, to flag potential and actual problems involving preventable risks to patients and staff.

There were 497 episodes (duty spans of 10 hours or more) of special nursing supervision involving 35 patients. Whilst the number of patients placed on one-to-one special nursing supervision increased by four, the number of episodes decreased by over 200 from the previous year. The Inspectorate (as mentioned in previous reports) was struck by the special nursing arrangements existing in the Sligo Mental Health Service, whereby any patient deemed to require special nursing observation was subject to automatic special supervision by two nurses regardless of whether two staff were necessary or not. This contributed to the stigmatisation of mentally ill and vulnerable people and to an unnecessary increase in the nursing budget. A revised policy and procedure relating to special nursing and close observation had been introduced to the service prior to this inspection, but had not been implemented. While it was acknowledged that consultant psychiatrists had ultimate responsibility for patient safety and may be obliged to order special nursing supervision this should always be done in the patient's best interest and not constrained by industrial relations agreements.

In 2002, there were 23 episodes of seclusion involving 13 patients in the Sligo service. The seclusion facilities, upgraded substantially in the past two years, appeared structurally appropriate with no dangerous fittings or blind spots. There was a written policy and procedure on the use of seclusion and a seclusion register was appropriately maintained. However, some of the signatures in the register were illegible. Ideally, the doctor authorising seclusion should sign their name in full and state their designation. The register should also contain information on the time seclusion commenced and the time it terminated. Patients whilst in seclusion should have an unrestricted view of a clock from the seclusion room. All nursing observation of patients whilst in seclusion as required by the Mental Treatment Act, 1945 were appropriately recorded. Although not required by statute, it was recommended that the nurses continue recording observations of patients by night if seclusion had not been terminated. A multi-disciplinary review should be completed and documented for each episode of seclusion to include doctors', nurses' and patients' views of the seclusion episode.

There were five recorded complaints made to the complaints manager and 20 Freedom of Information requests made in 2002. All appear to have been dealt with satisfactorily. There were no research projects governed by the Clinical Trials Act, 1987-1990 undertaken in the Sligo Mental Health Services. Information on the patients' complaints procedure and a notice on patients' rights under the Mental Treatment Act, 1945 and amending legislation were prominently displayed in the in-patient care areas. The imparting of information to detained patients should be adequately recorded in the case notes. The service should establish a system to ensure that the provision of information on patients' rights was recorded, including initial attempts that were unsuccessful because of patient's mental condition or inability to understand, further attempts at explanation of patients' rights should be facilitated by assigning a member of staff to review a patient's understanding of information and rights at intervals during their hospital stay.

In 2002, 8 patients were prescribed ECT, which was administered in the operating theatre department of Sligo General Hospital, because of the lack of adequate facilities at the Ballytivnan Unit. There was a written policy and procedure on the administration of ECT,

with a named consultant psychiatrist responsible for the ECT clinic and the induction of new doctors. A pre- and post-operative ECT nursing checklist was completed satisfactorily. There was an information leaflet available for patients to enable them to make an informed decision regarding the appropriateness of ECT for their particular circumstance. The information leaflet contained information about the risks of ECT and the availability of alternative treatment. The consent form for ECT was satisfactory.

A number of clinical files were examined. There were written instructions on filing of documentation within the record. The patient's name was clearly recorded on each continuation page and each newly-admitted patient had a full medical evaluation, including comprehensive admission notes, mental status examination, physical examination and a clear immediate management plan was appropriately recorded. Many files were bulky and contained loose clinical material within the file and some folders had a considerable collection of clinical materials stored in a back pocket. All this required review. Ideally, hand written records should be recorded in black ink. Each entry should be timed, dated and signed by whoever had assessed the need or provided care, treatment and support. Each signature should be accompanied by the individual's name in print and their job title and each record should have a signature bank placed on the inside cover. Where an assessment or intervention was made jointly, by more than one person, the note should include the name of staff present, unless it was a team meeting where staff attendance was minuted separately, in which case, the note should explain that the entry was related to a team meeting. A standard information form was sent to the GP and other persons responsible for the patient's follow-up on the day of discharge and an appropriate discharge summary ensued within a reasonable time thereafter.

All staff in the Sligo Mental Health Services wore identifying name badges indicating their designation within the multi-disciplinary team. A system should be put in place for informing patients of hospital charges. Patients at the Ballytivnan Unit had access to a shop on the hospital grounds. Patients in the admission unit had free and easy access to fresh air and those in the special care unit had easy access to an enclosed garden, under nursing supervision. The policy relating to patients absent without official leave was comprehensive. The management team for the services met formally on a monthly basis and appropriate minutes were kept.

A full risk management strategy should be introduced and appropriate training, recording and audit provided to ensure compliance with it. Such a strategy should include evaluation of the adequacy of existing arrangements, regular review systems to reassess the risks and a continuing programme of staff development in the assessment of risk. The corporate Health and Safety Statement available in the clinical area was not site-specific and was unsigned and undated. All of this required review.

The induction process for new staff was informal at ward level, although there was a two day induction training programme for permanent staff. Records of environmental health and safety audits should be retained centrally and at each location, indicating identified hazards classified by the degree of risk and naming the staff member with lead responsibility for addressing agreed risks within an appropriate timeframe. The Health and Safety

Committee, which seemed to meet infrequently, should monitor safety statements and safety audits. Revised safety statements should be introduced to all staff and all should sign a document indicating that they had read and understood its contents. There was a need for a written policy and procedure on the use of the pinpoint panic alarm system.

There was a policy and procedure manual for nursing staff, with an index of all policies and procedures. It was noted that there were several policies, procedures and protocols in place, some of which originated from the North-Western Health Board and others, were unit-specific. All policies and procedures should be formally introduced to relevant staff, ensuring awareness and understanding of content. Staff should sign a document to say that they have read, understood and intend to and are able to comply with the policy content.

Nursing documentation in the Sligo/Leitrim Mental Health Services related to the 'Roper' model of nursing. Nursing plans examined contained relevant information relating to nurses' observation of patients and changes in the patients' condition. The biographical data sheet for each admission recorded the patient's legal status, next-of-kin and name of GP. There was a need for a statement in the nursing assessment giving a physical description of patient, hair colour, height etc. History of allergies and drug sensitivities should also be recorded. If there were no known allergies or drug sensitivities this should be stated. The name of the patient's primary nurse should be entered in the nursing record and the records should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment. Similarly, nursing evaluation should include patients' views about their progress. All entries were accurately dated; time of entry should also be recorded using the 24-hour clock. The signature, in full, of the professional making the entry should be used with block lettering alongside the signature of the first entry. Nursing documentation was filed at the back of the medical file in an open pocket. The nursing documentation examined contained a number of loose pages. There were certain risks associated with loose pages in nursing documentation and the local service providers should review the current system of filing. Nursing records should be audited to assess standards of records and identify areas for improvement and staff development.

Three patients, two females and one male, were interviewed to ascertain their view of the services provided to them. All were of voluntary status. It was a first admission for one patient, while the others had a number of previous admissions. One had been an inpatient for some six months while the others ranged from six to fourteen days. All patients agreed they were treated with courtesy and dignity. Two patients were quite pleased with the nursing and medical staff, but one patient was somewhat disgruntled, alleging infrequency of consultations with consultant psychiatrists and junior doctors, whom they felt were off-hand and dismissive. The Inspectorate felt these opinions were coloured by the underlying medical condition. One patient was very pleased with the way psychological problems were fully explained as was the purpose and side effects of medications, but two patients felt these subjects were not fully explained to them. Two patients did not like that consultation took the format of mostly team meetings and they would prefer one-to-one encounters with both doctors and nurses. None of the patients were aware of their rights under

the Mental Treatment Act, 1945 and while these were written up and displayed in various areas of the Unit the patients had not paid any attention to them. Neither were they aware of any complaint procedure being in place. While they gave a high rating to the hygiene and cleanliness of the Unit, especially the bathrooms and toilets, when asked about the ward environment they were less enthusiastic. There was need for a quiet room where patients could relax — free from television and banter.

RECOMMENDATIONS

It is recommended that:

1. The building of the acute unit at Sligo General Hospital proceed immediately as per the 1992 agreed plan.
2. The service headquarters, medical, nursing and administration remain at the educational centre and adjoining building pending further discussion and agreement on the future location of the catchment area headquarters.
3. Mental health centres/sector headquarters and acute day hospitals, serviced by multi-disciplinary teams based and working out of these centres, be made available in each sector as set out in the body of the Report.
4. The future of the special care unit be considered in the context of the new rehabilitation service.

CHAPTER SEVEN

South-Eastern Health Board

CARLOW/KILKENNY MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 22 AND 27 AUGUST 2003

The Carlow/ Kilkenny service embraced five sectors (two in Co. Carlow and three in Co. Kilkenny) with an estimated combined population of 126,353. It provided, in addition to general adult services, a specialised service for the psychiatry of later life and for child and adolescent psychiatry and hoped shortly to introduce a specialised, consultant-led, service for rehabilitation. The general adult service was delivered through a combination of a limited range of community-based provision, acute in-patient care at the new psychiatric unit at St. Luke's Hospital, Kilkenny and a variety of other services, including day care and rehabilitation at St. Dymphna's Hospital, Carlow and at St. Canice's Hospital, Kilkenny.

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 126,353 was divided into five sectors as follows:

Sector	Population
Carlow North	23,007
Carlow South	23,007
Kilkenny East	26,780
Kilkenny North	26,780
Kilkenny West	26,779

IN-PATIENT CARE

In-patient care was provided at St. Dymphna's Hospital, Carlow which had 119 beds in two male and three integrated units and St. Canice's Hospital, Kilkenny, which had 92 beds in four integrated units. In-patient care was now provided in St. Luke's Hospital, Kilkenny which opened in March 2003.

Age and Length of Stay of all Patients at 31.12.02 — ST. DYMPNA'S HOSPITAL, CARLOW

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	11	9	2	2	24	26.4
3-12 Months	—	—	—	1	1	1	3	3.3
1-5 Years	—	—	2	6	6	2	16	17.6
> 5 Years	—	—	8	21	11	8	48	52.7
All Lengths of Stay	—	—	21	37	20	13	91	100
% of Total		—	23.1	40.7	21.9	14.3	100	

In-Patient Population Diagnosis at 31.12.02 — ST. DYMPNA'S HOSPITAL, CARLOW

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
3	18	—	5	1	1
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
2	5	—	25	31	91

Status of In-Patients on date of Inspection 2003 — ST. DYMPNA'S HOSPITAL, CARLOW

Status	Male	Female	Total
Voluntary	41	21	62
Temporary	2	2	4
P.U.M.	2	—	2
Ward of Court	—	—	—
Total	45	23	68

Age and Length of Stay of all Patients at 31.12.02 — ST. CANICE'S HOSPITAL, KILKENNY

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	12	9	5	5	32	40.5
3-12 Months	—	—	2	2	6	1	11	13.9
1-5 Years	—	—	—	5	5	6	16	20.3
> 5 Years	—	—	—	3	5	12	20	25.3
All Lengths of Stay	—	1	14	19	21	24	79	100
% of Total	—	1.3	17.7	24.1	26.6	30.3	100	

In-Patient Population Diagnosis at 31.12.02 — ST. CANICE'S HOSPITAL, KILKENNY

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
9	31	—	13	5	3
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
2	9	1	5	1	79

Status of In-Patients on date of Inspection 2003 — ST. CANICE'S HOSPITAL, KILKENNY AND PSYCHIATRIC UNIT, ST. LUKE'S HOSPITAL, KILKENNY

Status	Male	Female	Total
Voluntary	34	39	73
Temporary	2	3	5
P.U.M.	3	—	3
Ward of Court	2	—	2
Total	41	42	83

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
706	5.6	172	24.4	92.9	7.1	691	18

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	3	55	376
Day Centres	10	157	135
Out-patient clinics	13	419*	2,247

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
10	46	5	50	7	90

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
19	26.5	291.16	119.42	13

COST

The cost of the Carlow/Kilkenny Mental Health Service was €33.7 million in 2002.

GENERAL COMMENTS

The two services of Carlow and Kilkenny had now amalgamated as one after successful negotiations and planning. As a consequence, a new enthusiasm seemed to pervade the service. The most obvious sign of this unity was the new Department of Psychiatry in St. Luke's Hospital, Kilkenny. Although there had been a threat that this unit would be taken

over for general medical purposes, this had not happened and the 45-bedded unit with six assessment beds for later-life psychiatry had opened on 5 March 2003. It was a well-designed unit with six offices for consultants. The observation areas were well-planned and allowed the performance of this function adequately and with the preservation of patient dignity. Since opening, the unit had been running at approximately 70% occupancy. The number of admissions, compared to the combined numbers at the admission units at St. Canice's Hospital and St. Dymphna's Hospital, had dropped by a third as well as the length-of-stay, having on average, come down to 19 days from the high twenties. It had, however, to be kept in mind that a policy of "stepping down" admission patients from the Unit to the Greenbanks and Altamont Residences in Carlow and Kilkenny respectively had been introduced — so perhaps the overall residential length-of-stay had not declined that much, if at all.

The difficulties of amalgamation were evident elsewhere and at times the Inspectorate got the impression that there were still two separate and duplicating services in operation at a cost of over €30 million.

A newly-established service for the later-life psychiatry had been put in place and was functioning well. A rehabilitation consultant and a consultant for the psychiatric disorders of intellectual disability were required and some specialisation for liaison consultation in St. Luke's Hospital was also needed.

Community facilities needed strengthening and, in particular, there was an obvious requirement for day hospitals, community-based facilities and sector headquarters as the day hospitals at St. Dymphna's Hospital and St. Canice's Hospital could not be regarded as functioning as such. The use and staffing of community residences should be reviewed with a view to rationalisation and, perhaps, the conversion of Altamont to day hospital and sector headquarter usage, particularly with the rethinking of the "stepping-down" idea.

Between them, St. Dymphna's Hospital, St. Canice's Hospital and the acute unit, St. Luke's Hospital had a total of 151 residents on the day of inspection. Fifteen of these, in Kelvingrove, were intellectually disabled, leaving approximately 90 elderly patients in five wards, virtually all of whom were over age 65 years of age and many much older. These patients required care appropriate to the elderly, rather than of psychiatry. Both hospitals should, therefore, be de-designated and their activities integrated with the generic services for the elderly of the region.

In 2002, 14 patients were admitted to St. Dymphna's Hospital, Carlow on temporary admission orders and 12 patients had their temporary admission orders extended. Four patients admitted as voluntary patients were re-graded to involuntary status during their hospital stay: one patient admitted as an involuntary temporary patient was re-graded to voluntary status. At St. Canice's Hospital, there were 34 temporary admissions in 2002 and four extensions of involuntary admission orders: five patients admitted as voluntary patients were re-graded to involuntary during the course of their hospitalisation, three patients admitted as voluntary patients were re-graded to temporary status. Two patients admitted

to St. Canice's Hospital were wards of court. During 2002, 20 patients took their own discharge from St. Canice's against medical advice. Procedures were in place to follow-up those patients if deemed clinically appropriate. There was an admission checklist completed by the primary nurse for all admissions to the Department of Psychiatry, St. Luke's Hospital, Kilkenny and these had been introduced in tandem with the opening of the Department of Psychiatry.

During 2002 there were 70 accidents to patients at St. Dymphna's Hospital; two were deemed serious, there were 22 assaults on patients by other patients but none were deemed serious. Of the nine recorded assaults on staff, two resulted in minor injury. At St. Canice's Hospital there were 85 accidents to patients, one was deemed serious and 46 resulted in minor injury. There were 10 recorded accidents to staff; none were deemed serious. Of the 9 assaults on patients by other patients and 27 assaults on staff, none were deemed serious.

In 2002, 14 patients were prescribed ECT in the combined Carlow/Kilkenny mental health service. ECT was now administered at the Department of Psychiatry, St. Luke's Hospital where there was a dedicated ECT suite comprising of waiting, treatment and recovery areas. A named consultant psychiatrist was responsible for the ECT clinic and the induction of all junior doctors. The consent form for ECT was satisfactory. Prior to the completion of the consent form medical practitioners confirmed that they had explained to the patient the nature and purpose of ECT treatment. Documentary procedures relating to ECT, including a pre- and post-ECT nursing checklist appeared satisfactory.

There were no research projects governed by the Clinical Trials Act, 1987-1990 undertaken in the Carlow/Kilkenny mental health service. Two complaints and five Freedom of Information requests were made in Carlow and nine complaints and six Freedom of Information requests were made in the Kilkenny service in 2002. All appear to have been dealt with satisfactorily.

All patients irrespective of their status should be informed of their rights under the Mental Treatment Act, 1945. Information on patients' rights, including the local complaints or dissatisfaction procedure was available in the hospital brochure. An entry should be made in the patient's clinical documentation that an oral and written explanation had been given, with an indication of the patient's understanding.

Two patients, involving 1,318 episodes, were placed in seclusion at St. Dymphna's Hospital in 2002. There were 46 episodes of seclusion in the Kilkenny service involving two patients and 12 patients were placed on one-nurse to one-patient special nursing supervision with 41 episodes involving duty spans of ten hours or more, compared to 11 patients with 374 episodes placed on special nursing supervision at St. Dymphna's Hospital.

In 2002, there were 219 consultant liaison assessments at St. Luke's Hospital resulting in 24 admissions to the mental health service and a further 71 referred to the mental health service out-patient department. Out-patient facilities within the entire catchment area were adequate, with the exception of the Callan out-patient department where space was

at a premium. An out-patient appointments system was in operation and there was a waiting list of six patients in the north Carlow sector and 16 patients in the south Carlow sector of approximately six weeks. All patients on the waiting list were prioritised. An appropriate follow-up procedure was in place for patients who failed to attend out-patient appointments.

Revised policy guidelines and protocols to assist staff in making decisions about clinical and administrative matters relating to the appropriate care of patients and the needs of staff providing that care were provided to the Inspectorate. Policies, guidelines and protocols should be formally introduced to relevant staff in order to ensure awareness and understanding of content. Staff should sign that they have read, understood and are able to comply with policy content.

There was one integrated clinical file which contained inputs from all professional staff working within the multi-disciplinary team. Written instructions on the filing of documentation within the record were available. The patient's name was clearly recorded on each continuation page of all files examined. Each newly-admitted patient to the Department of Psychiatry, St. Luke's Hospital, Kilkenny had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and immediate management plan clearly documented in notes examined.

The quality of nursing documentation was very satisfactory: all notes examined were signed and dated by the assessing nurse, as was the nursing care plan and care-plan evaluations. The delivery of nursing care utilised care-plan documentation using the 'Peplau' model, incorporating elements of the 'Oram' model. Nursing records appeared to contain all relevant information relating to the nursing observation of patients and changes in patients condition. Records were written clearly, accurately dated and timed using the 24-hour clock. All signatures of professionals making entries were legible. A number of abbreviations were noted and there was a policy of approved abbreviations.

Three patients were interviewed at the new unit at St. Luke's Hospital to ascertain their views of the service provided. All patients were satisfied with the admitting procedures at the unit. They were satisfied with the courtesy and helpfulness of the staff. However, one patient was not happy with the frequency of nursing intervention. He felt the nurses were always too busy with other matters. All patients had been introduced to their Consultant Psychiatrists and were happy with the frequency of their consultations. The patients had been informed about the nature of their psychological problems and their prescribed medication. Two patients would appreciate getting written information on their medications. While they knew the name of their primary nurse, one patient was not aware of his care plan. Two patients had been informed of their rights under the Mental Treatment Act, 1945 but were not aware of any procedure for making formal complaints. All agreed that the menu cycle, quality and quantity of food could be improved. All patients described the cleanliness of the toilets and bathrooms as excellent. There were adequate occupational therapy facilities and relaxation exercises. When asked how they would like to see the services improved one replied that he would like the services of counsellors to be available.

RECOMMENDATIONS

It is recommended that the proposed further development of this service proceeds on the lines set out by the management team. The Inspectorate would suggest that some consideration might be given to the following issues:

1. The de-designation of both St. Dymphna's Hospital and St. Canice's Hospital and their integration with the generic services for the elderly.
2. The acquiring of suitable premises in Carlow and Kilkenny to serve as day hospitals.
3. A reassessment of current community residential properties with a view to adapting some to other more urgent uses, such as Altamont to serve as a sector headquarters and community mental health centre for Kilkenny.
4. A review of existing nurse staffing arrangements towards a more efficient use of skilled personnel in more innovative forms of community-based service provision.

TIPPERARY MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 1 AND 14 MAY 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 135,620 was divided into five sectors as follows:

Sector	Population
Clonmel East	26,380
Clonmel West	25,637
Tipperary	25,774
Thurles	30,294
Nenagh	27,535

The Tipperary Mental Health Services provided acute in-patient care at the 50-bedded St. Michael's Unit in St. Joseph's Hospital, Clonmel, and continuing care at St. Luke's Hospital, Clonmel, which had 174 beds in three male, two female and two integrated wards together with a range of community-based services.

Age and Length of Stay of all Patients at 31.12.02 — ST. MICHAEL'S ACUTE UNIT

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	4	14	17	3	6	44	88.00
3-12 Months	—	1	—	3	—	—	4	8.00
1-5 Years	—	—	—	1	—	—	1	2.00
> 5 Years	—	—	—	—	—	1	1	2.00
All Lengths of Stay	—	5	14	21	3	7	50	100.00
% of Total	—	10.00	28.00	42.00	6.00	14.00	100.00	

In-Patient Population Diagnosis at 31.12.02 — ST. MICHAEL'S ACUTE UNIT

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
4	6	1	24	4	—
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
1	2	4	2	2	50

Status of In-Patients on date of Inspection 2003 — ST. MICHAEL'S ACUTE UNIT

Status	Male	Female	Total
Voluntary	21	22	43
Temporary	6	3	9
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	27	25	52

Age and Length of Stay of all Patients at 31.12.02 — ST. LUKE'S HOSPITAL, CLONMEL

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	3	—	1	—	5	3.1
3-12 Months	—	—	7	8	7	—	22	13.8
1-5 Years	—	—	6	15	5	7	33	20.8
> 5 Years	—	—	6	53	14	26	99	62.3
All Lengths of Stay	—	1	22	76	27	33	159	100.00
% of Total	—	0.6	13.8	47.8	17.0	20.8	100.00	

In-Patient Population Diagnosis at 31.12.02 — ST. LUKE'S HOSPITAL, CLONMEL

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
11	74	5	14	7	4
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
1	5	11	27	—	159

Status of In-Patients on date of Inspection 2003 — ST. LUKE'S HOSPITAL

Status	Male	Female	Total
Voluntary	84	70	154
Temporary	3	2	5
P.U.M.	4	1	5
Ward of Court	5	2	7
Total	96	75	171

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
1,102	8.1	195	17.7	84.8	15.2	1,127	18

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities — Tipperary South Riding

	Number	No. of Places	No. of persons attending
Day Hospitals	3	25	954
Day Centres	2	38	149
Out-patient clinics	7	324*	955

*No. of out-patient clinics held in 2002

Day Facilities — Tipperary North Riding

	Number	No. of Places	No. of persons attending
Day Hospitals	2	25	438
Day Centres	2	30	56
Out-patient clinics	2	367*	681

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
11	39	3	22	1	19

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
10	30	189	71	7

COST

The cost of the Tipperary Mental Health Service was €15.2 m in 2002.

GENERAL COMMENTS

The mental health services for the county of Tipperary were the responsibility of two health boards. South Riding services were provided by the South-Eastern Health Board and North Riding services were provided by the Mid-Western Health Board. Mid-Western Health Board personnel provided community care services for the North Riding while in-patient care at St. Michael's Unit, Clonmel was provided by South-Eastern Health Board staff, leading to discontinuity of care. A new in-patient unit at Nenagh General Hospital

was planned. As this unit would service a catchment area of only 60,000, the Inspectorate felt that it was not cost efficient to sustain a service for this size and could not provide a comprehensive range of services for the two sectors.

The Inspectorate was disappointed to learn that the newly-provided services in Cashel had not commenced, although assurance was given that commencement was imminent. These services included a 12-place residence for the intellectually disabled, a high-support residence for a similar number of long-stay mentally ill patients, a sector headquarters, and mental health centre and day hospital for that sector. This latter initiative would allow the present shared arrangement in Clonmel to service Clonmel alone. However, a sector headquarters for Clonmel was required. There had been plans to increase the premises available in Tipperary town to enable day hospital and day centre services to operate separately. Facilities in St. Michael's admission unit had improved with the creation of an acute observation unit on the female side; however, it was small and not entirely appropriate. A similar provision was intended for the male side. Long-term plans existed for a dementia unit in Cashel and for an 18-place, high-support residence for Clonmel. The newly-created later-life service did not have self-contained acute assessment beds but had sufficient continuing care beds. A headquarters for this service had become available with a limited day hospital facility in the Rosehill premises. Although this service had recruited the nucleus of a team there was, as yet, no social worker or psychologist exclusive to it.

Neither Nenagh nor Thurles had acute day hospital services, which belied the supposed emphasis on community care in these sectors. The accommodation in the day hospital in Nenagh was not appropriate for this purpose but was suitable for sector headquarters. However, there was the promise of larger premises in the town for day hospital purposes. Out-patient clinics were held in the house, which exacerbated matters. Such clinics should be held at a primary care clinic, to encourage primary care involvement in the care of psychiatric disorder. This also applied to Thurles and to Tipperary where out-patient clinics were also held in day premises. In Thurles, it would be advisable to have an interchange between the day hospital and day centre premises or adapt the existing premises to day hospital usage exclusively, with alternative premises sourced for a day centre operation. In Tipperary, the new day centre should be changed to a day hospital, a purpose for which it was more suitable. The day centre operation should revert to the existing day hospital premises on the first-floor of the St. Vincent's building, with the out-patient clinic operating in the adjoining primary care premises.

Arrangements in St. Luke's Hospital were chaotic. Intellectually disabled patients were mixed indiscriminately with physically ill and newly-admitted patients in a manner that, both from civil rights and a clinical point of view, was quite unacceptable. An admission policy was clearly not adhered to: patients deemed in need of admission were admitted directly to beds in the intimidating conditions of the 100-bed wards. The admission rate was among the highest in the country.

The absence of any rehabilitatory activity was clearly evident in the long-stay wards, apart from those dedicated to the elderly, for whom other solutions were appropriate. There was an indisputable need for a specialised rehabilitation team for this service. This need

was further exemplified by the high number of patients who became new long-stay in 2002.

Matters of documentation were, in some respects, quite unsatisfactory. In St. John's ward there had been four episodes of seclusion involving three patients since the beginning of the year and there were no medical entries in medical case-notes documenting these seclusions. In St. Brigid's ward, NCHDs signed seclusion orders and there were no consistent or informative medical entries describing these episodes. The most recently admitted patient had not been medically seen until four days following admission. One patient had her temporary period of detention extended but this fact was not medically recorded, nor a reason given. One patient was being specialised on a twelve-hour basis but it was not clear that this was being consultant-reviewed on a daily basis.

There were 168 patients admitted to the Tipperary Mental Health Services on temporary certificates in 2002: six had their detention period extended. Eight patients aged sixteen years or younger were admitted to this service in 2002. In 2002, 23 patients admitted as voluntary patients were re-graded to involuntary status during the course of their hospitalisation; 35 patients admitted as involuntary patients were re-graded to voluntary during their hospital stay. During 2002, 79 patients took their own discharge against medical advice from inpatient care. Follow-up procedures were in place for these patients if deemed clinically appropriate. In addition to 13 episodes of serious self-harm by patients, there were four suicides by non-hospitalised patients and one probable suicide by a hospitalised patient.

There were no recorded complaints made by patients or patients' relatives to the local complaint manager in 2002. Nine requests for information under the Freedom of Information Act, 1997 were made during 2002 and all appear to have been dealt with satisfactorily. There were no research projects governed by the Clinical Trials Act, 1987-1990 undertaken in this service.

There were 350 episodes of seclusion at St. Luke's Hospital, involving 34 patients and 104 episodes of seclusion at St. Michael's Acute Unit, involving 51 patients on seclusion for periods of 12 hours or more and some authorisations were by junior doctors. A new safe room was under construction at the female acute psychiatric unit which would supplement the existing room on the male side. Where the use of seclusion appeared high, a seclusion reduction plan should be produced to include monitoring the effect of any change in management regime on the attitude and behaviour of patients. Facilities that were structurally inappropriate continued to be used for seclusion purposes. The seclusion policy and procedure was under review at the time of this visit. The seclusion register was appropriately maintained and nursing and medical documentation checked in relation to seclusion episodes were cross referenced to the seclusion register. Patients while in seclusion should have an unrestricted view of a clock.

During 2002, 30 patients were placed on one-nurse to one-patient special nursing supervision and there were 490 episodes of special nursing supervision involving duty spans of ten hours or more. A new policy and procedure relating to special nursing supervision

had been produced in draft form. This policy should be introduced to all relevant staff as soon as possible.

There was a dedicated ECT treatment suite, with waiting, treatment and recovery areas equipped to a satisfactory standard. ECT was prescribed for 33 patients in the Tipperary Mental Health Service in 2002. Three of those patients were hospitalised on temporary certificates. There was a written policy and protocol document on ECT with a named consultant psychiatrist responsible for the procedures. There were appropriate records in the patients' clinical notes of discussions with the patients on the nature of the procedure, the risks/benefits attached to the procedure and of the discussions with family, if appropriate. The physical examination of the patient prior to ECT treatment was comprehensively recorded in the medical notes.

There were 117 accidents to patients in the combined St. Luke's and St. Michael's service during 2002; ten of those were deemed to be serious. There were 29 accidents to staff; one resulted in a minor injury. There were 36 assaults on patients by other patients; 19 resulted in minor injury. There were 23 assaults on staff; two resulted in minor injury and one was deemed serious.

The Inspectorate welcomed the introduction of designated smoking areas at some locations since the previous visit. However, there remained evidence of smoking in bedrooms in some of the long-stay wards. This should be actively discouraged. Smoking should not be allowed in single occupancy rooms or in the television room. It was recommended that this policy be extended to all other areas within St. Luke's Hospital.

A new information leaflet was available for patients at the St. Michael's Admission Unit. When next reviewed, this leaflet should contain information on complaint procedures, hospital charges and information on how to contact the Chaplaincy Service. Information on patients' rights under the Mental Treatment Act, 1945 and amending legislation was prominently displayed at all treatment locations but it was not clear how this information was communicated to patients. Voluntary patients should be told if they wish to leave hospital that they must discuss this with their consultant, or in his or her absence the clinical nurse manager. All policies, procedures and guidelines were under review.

A comprehensive drug management and administration policy, dated April 2003 had been produced in draft form, but had not been introduced in the clinical area. Other draft policies related to aggressive incidents, nursing escorts, admissions, seclusion, etc. All of these policies and guidelines should be headed with a hospital title, be individually numbered, the date of ratification and by whom ratified should be recorded. A computerised index of all policies should be kept and revised and superceded policies should be removed. One copy should be stored in a central file for future reference.

A number of current prescription cards and drug administration cards were examined in the course of this inspection. The legibility of individual prescriptions varied. Written instruction for the use of prescription cards was required. This would be included in the

new draft policy document. All prescriptions should be signed in full and dated individually.

This service had a strategic development plan, setting out how the service objectives were to be met within a given timeframe. This plan was rolled forward on an annual basis.

There was a written safety statement for the hospital and local units, adhering to the standards and procedures set by the Safety and Welfare at Work Act, 1989. The safety statement available in local units was unsigned, undated and there was no evidence that the safety statement was reviewed annually. Staff had not signed any of the safety statements in the ward areas examined by the Inspectorate although there was provision to do so. There was an environmental safety audit sheet but it was not clear when the last safety audit had been undertaken. There was a need for the safety committee to meet more often and address some of the deficiencies highlighted here. The fire protection system was a modern one; written fire orders were updated in the weeks prior to the visit, inspections were dated and signed and there were appropriate fire-drills for staff. There was a personal alarm system installed at certain wards at the services. There was a need for written guidelines for staff on the use of the panic alarm system. Security was provided on the grounds of St. Joseph's Hospital and staff had access to the security service as required.

The policy review committee should provide guidelines for staff on the management of illicit drug-use/drug-related incidents, setting out action to be taken by staff if there was suspicion of illicit drug abuse or supply on the hospital premises. Arrangements should be made with the Gardai for the disposal of illicit drugs or dangerous articles, once confiscated.

A number of clinical files were examined. Each newly-admitted patient had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and clear immediate management plan documented in the medical notes. There was a comprehensive discharge checklist which was completed satisfactorily. A standard information form was given to the patient on the day of discharge, and a summary sent to the General Practitioner and others responsible for follow-up care. Written instruction on filing of documentation within the medical record was required and, while there was provision for the recording of the patients name on each continuation page, this was not always recorded. The storage of loose clinical material within the medical file should be reviewed as there were risks associated with mis-filed or lost clinical information or delays in accessing pertinent information. A comprehensive policy and procedure relating to patients' absencing themselves from the hospital without official leave was in draft form. This, once ratified, would be included in the new policy and procedure manual.

The 'Peplau' model of nursing was used in the Tipperary Mental Health Service and there was appropriate training for staff on this nurse care planning system. Care plans were reviewed weekly or more often if necessary. The standard of nursing documentation examined at the St. Michael's male admission unit was high: nursing records contained relevant information relating to the observation of patients and changes in patients' condition relating to progress made with nursing intervention for identified problems. Records confirmed

how patients settled into the ward at the end of their first day of hospitalisation. All entries were made as soon as possible after the event to which they related. All entries were accurately dated using the 24-hour clock. The biographical data sheet for each admission was completed satisfactorily and there was an audit of the nursing records underway to assess standards of record-keeping and identify areas for improvement and staff development.

The quality and choice of food for patients in this service was satisfactory. The cleanliness of food preparation areas was also satisfactory, although some improvement was required in the physical environment of some of the dining areas. The evening tea for patients was provided at 4.30pm; this should be reviewed with a view to providing it at a more socially acceptable time.

Three voluntary patients were interviewed to assess their opinion of the psychiatric services provided. All the patients were pleased with the helpfulness and courtesy of the staff and with the frequency of their consultations with both medical and nursing staff. Each patient received a form on admission, indicating the name of their consultant and NCHD, as well as the names of the nurses and the name of their primary nurse. In the event that the primary nurse was off duty on a particular day, the name of his/her replacement was posted up on the ward area. All patients had the nature of their illnesses explained to them. However, the patients would prefer more in-depth, written information on their medication, the indications for its use and any potential side-effects. Two of the patients would have preferred more privacy when being interviewed, especially by their consultant psychiatrist. Two patients also said they were not aware of their rights under the Mental Treatment Act, 1945 but the Inspectorate observed these rights prominently posted up in the patient areas. No patients were aware of any complaint procedure or of a nursing care plan. All patients were satisfied with the quality of the food provided. The patients were also pleased with all aspects of hygiene and they regarded the ward activities, including occupational therapy, recreational therapy etc. as quite acceptable and useful.

Finally, when the patients were asked how they would wish to see the psychiatric services improved all agreed they were quite pleased with the standards of services prevailing.

RECOMMENDATIONS

It is recommended that:

1. The Cashel initiatives become operational without delay.
2. An efficient administrative and clinical system be introduced to rationalise the use of the various clinical locations in St. Luke's to ensure that patients with similar problems and needs are correctly placed.
3. A rational and effective admission policy be devised to avoid unnecessary and inappropriate admissions and to ensure that admission beds are available for emergency admissions to end the totally unacceptable practice of admitting patients directly to the unsatisfactory conditions of the 100 bed ward.

WATERFORD MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 10 APRIL, 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 116,559 was divided into four sectors as follows:

Sector	Population
West Waterford	33,839
Mid Waterford	33,839
East Waterford	33,839
South Kilkenny	15,042

The Waterford Mental Health Services provided acute in-patient care at the Department of Psychiatry, Waterford Regional Hospital, which had 45 beds. Continuing Care and Care of the Elderly through a specialised Later-life team was provided at St. Otteran's Hospital, which had 132 beds and Community Services in the sectors.

Age and Length of Stay of all Patients at 31.12.02 — WATERFORD REGIONAL HOSPITAL AND ST. OTTERAN'S HOSPITAL

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	17	11	7	4	40	28.2
3-12 Months	—	—	1	3	3	5	12	8.5
1-5 Years	—	—	5	8	8	16	37	26.0
> 5 Years	—	—	3	19	17	14	53	37.3
All Lengths of Stay	—	1	26	41	35	39	142	100
% of Total	—	1.0	18.2	28.8	24.6	27.4	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
23	32	11	34	17	1
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
6	9	—	8	1	142

Status of In-Patients on date of Inspection 2003 — ST. OTTERAN'S HOSPITAL

Status	Male	Female	Total
Voluntary	54	51	105
Temporary	5	4	9
P.U.M.	—	—	—
Ward of Court	1	4	5
Total	60	59	119

Status of In-Patients on date of Inspection 2003 — DEPT OF PSYCHIATRY, WATERFORD REGIONAL HOSPITAL

Status	Male	Female	Total
Voluntary	13	21	34
Temporary	4	4	8
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	17	25	42

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
787	6.8	302	38.4	92.8	7.2	796	16

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	20	437
Day Centres	3	47	169
Out-patient clinics	6	408*	5,233

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
11	50	3	21	2	27

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
9	19.5	166.5	49.85	8.75

COST

The cost of the Waterford Mental Health Service was €12.8 million in 2002.

GENERAL COMMENTS

Once again, the Inspectorate reported little effective change in this service. Matters were at something of a standstill, partly because of lack of capital resources. If, as the Inspectorate believed, the plan was to close St. Otteran's in favour of improved and extended community services and the establishment of more specialised rehabilitation, liaison and

intellectual disability teams, then an accelerated programme of development was required, informed by more frequent and focussed senior management team meetings.

It was the Inspectorate's view that priority should be given to the transfer of the 15 patients from St. Clare's ward to Grangemore, the former RMS and nurse training house in the front of the St. Otteran's campus. The Inspectorate understood however, that the short-term plan was to transfer the patients from St. Enda's ward where conditions were unacceptable to the refurbished Grangemore and, when purpose built accommodation was available to further transfer them on, thus releasing Grangemore as a high-support area for patients presently in St. Clare's ward. A specialised multi-disciplinary team should be established immediately with a more widespread rehabilitation remit. The lack of specialised input of this kind was reflected in the fact that the number of in-patients in St. Otteran's Hospital had only fallen by two during 2002, and by the fact that the number of psychologists had fallen to one with one social worker and no occupational therapist in the service.

The second priority should be the establishment of a second premises in Waterford City to complement Brook House. This latter currently served a multitude of functions, some only partly and inadequately. Brook House should be dedicated to the Mid-Waterford and South Kilkenny sectors to serve as a mental health centre and acute day hospital for these sectors. Further premises should be acquired to serve the same functions for the East Waterford sector. There was a need for a wide range of professional staff such as psychologists, social workers and occupational therapists to strengthen the community services.

Thirdly, the location of the continuing care service for the elderly required thoughtful consideration. The Inspectorate understood that there was a proposal to move this component of the service to a more suitable location in St. Patrick's Hospital with the added purpose of integrating it more closely with the generic later-life services. In the meantime, and having regard to the fact that all of the patients were voluntary, there was no reason why this unit should not have been de-designated.

Out-patient clinics within the catchment area were suitably located and maintained at a reasonable standard, affording adequate privacy and confidentiality for patients. There was an appointments system ensuring that patients had a minimal wait for attendance in some locations and this appeared to be working well.

There were 57 temporary admissions to the Waterford Mental Health Service in 2002; 11 involuntary admissions were re-graded to voluntary and five patients admitted as voluntary patients were re-graded to involuntary patients during their hospital stay. Nine patients had their involuntary admission orders extended during 2002. In 2002, 14 patients took their own discharge from the service against medical advice. Appropriate procedures were put in place to follow-up on those patients, if deemed necessary. There were 16 deaths of hospitalised patients during 2002.

There were two formal complaints made by patients or patients' relatives to the local complaints manager and five requests under the Freedom of Information Act, 1997 in 2002. There were written procedures for dealing with complaints from patients and families but these should be on display or brought to the attention of patients. This service had an information leaflet which was given to all patients informing them of their rights under the Mental Treatment Act, 1945. The provision of information on patient's rights was recorded by the admitting doctor and, subsequently, by the consultant.

There were 36 episodes of seclusion, involving 15 patients in 2002; these episodes were usually for a short duration and authorised, for the most part, by junior doctors. As access to the seclusion room at the Department of Psychiatry, Waterford Regional Hospital was off the corridor adjacent to the nurses' station, only reasonable privacy was afforded to patients. This facility was structurally appropriate and the furnishings were satisfactory. A seclusion policy and procedure was under review. The seclusion register was appropriately maintained and nursing observations documented. All nursing and medical implementation in relation to seclusion episodes checked were cross-referenced to the special seclusion register.

The seclusion room in use in St. Enda's Ward, St. Otteran's Hospital was not safe and the ventilation was not up-to-standard. The nursing care plan in relation to each seclusion episode should include information on events prior to the seclusion episode, note the actual behaviour of the patient and interventions used prior to the seclusion episode. Information on the patient's response to seclusion during and after the event should be clearly documented. All patients should have an unrestricted view of a clock from the seclusion rooms. Five patients were placed on special, one-to-one nursing supervision and there were 11 episodes of special nursing supervision involving duty spans of eight hours or more.

There were 98 accidents to patients at the Department of Psychiatry, Waterford Regional Hospital and 42 resulted in minor injury. There were four accidents to staff at the same location, three resulting in minor injury. There were 158 accidents to patients in St. Otteran's Hospital, 80 resulting in minor injury and two in serious injury and a further 56 accidents to staff, 10 resulting in serious injury. There were eight assaults on patients by other patients at the Department of Psychiatry resulting in no detectable injury. There were 24 assaults on patients by other patients at St. Otteran's Hospital: four resulted in minor injury. There were 24 assaults on staff at the Department of Psychiatry; 13 of those resulted in minor injury. One assault on a staff member at St. Otteran's Hospital was deemed serious. The number of accidents to patients at both locations remained high by the standards of other hospitals; however, this may indicate the willingness of staff to report incidents, common mistakes and accidents immediately they occur and also the robustness of the formal system for reporting of accidents and incidents. There was a need for an analysed report of accidents and incidents by date, time and location with a view to developing a system of tracking and trending accidents.

There were no research projects governed by the Clinical Trials Act, 1987 — 1990 undertaken in the Waterford Mental Health Service in 2002. There was a written policy for the

management of illicit drug use or drug-related incidents, setting out the actions to be taken by staff.

There was a revised and updated written policy for the ordering, prescribing, storing and administration of medicines. A new medication sheet and drug-recording administration sheet had been produced and this was to be introduced on a pilot basis in the Department of Psychiatry and then extended to St. Otteran's Hospital. Some of the drug recording cards at St. Clare's Ward, St. Otteran's Hospital were dated 1999 and should be rewritten. At a number of locations, the drug administration cards should be rewritten, as the numbers of discontinued prescriptions were greater in number than current prescriptions with an increased risk factor of drug error.

A comprehensive information leaflet on matters pertinent to a patient's stay in hospital was made available to all patients. In addition, the Inspector welcomed the availability of fact sheets on tranquillisers, ECT, patients' rights and monies, psychotherapy and lithium therapy, which were available to patients at the Department of Psychiatry, Waterford Regional Hospital.

The quality of food for patients in this service had improved since the last visit of inspection. There was a printed menu, which was changed regularly with appropriate choice for all patients at Waterford Regional Hospital. There was a need for the auditing of standards on provision of catering facilities at St. Enda's Ward, St. Otteran's Hospital. Otherwise, the physical environment of the dining areas and quality of tableware at other units was satisfactory. Meals were provided for patients at socially acceptable times. There was an appropriate training programme for catering staff on hygiene and there was reasonable availability of snacks and hot and cold drinks for patients. All patients had free and easy access to a shop on the campus at Waterford Regional Hospital.

All staff in this service wore an identifying name badge, indicating their designation within the multi-disciplinary team. Staff should ensure that this badge was visible to patients and visitors at all times while on duty.

Nursing records using the 'Oram/Peplau' model of nursing were appropriately recorded and contained relevant information relating to the observation of the patient, changes in the patients medical condition, progress made with nursing interventions and whether or not the patient settled into the ward on the first day of admission. The biographical data sheet for each admission was appropriately recorded. In some instances, the nursing assessment was not completed. Also, the nursing objective plans were unsigned. It was noted in a number of files that the address and phone number of the patient's general practitioner were not recorded. There was provision for the recording of the patient's primary nurse in the nursing records but this was not always recorded. At the time of the inspection, a system of auditing the nursing care plans was about to be introduced with a view to identifying areas for improvement.

A number of clinical files were examined and it was noted that all newly-admitted patients had a full medical evaluation, including comprehensive admission notes, mental state

examination, physical examination and clear management plan documented in the notes. Whilst there was provision for the recording of the patients name on each continuation page this was not always recorded in the notes examined. Written instructions on filing of documentation within the medical record were required. The signature of the doctor making the input into the notes in some instances was illegible and designation was not always recorded. Ideally, the doctor making an entry in the medical notes should write his or her name in capitals, then sign the entry and record his or her designation. This would enable identification of the practitioner in the future. The time of assessment was not always recorded. Recording of time using the 24-hour clock was useful in determining any delays in assessment or treatment.

A Nursing Committee was reviewing all policies at the time of this inspection and a number of revised policies and procedures had been produced in draft form. A computerised index of all policies should be kept and revised and superceded policies should be removed with one copy retained in a central file for future reference. All new policies and procedures should be formally introduced to relevant staff who should sign that they have read, understand and are willing to comply with them.

The service should re-activate the five-year strategic development plan setting out the service objectives and how they are to be met. Internal quality audits should be undertaken at yearly intervals on specific components of service provision. The outcome of the audits should be recorded and discussed at management meetings and included in an annual report, which should outline the service achievements during the year and objectives for the following year. As patients' views are a valuable reference tool when evaluating service provision, a formal system should be introduced where their views are sought on various aspects of the services provided.

Three patients were interviewed at the acute psychiatric unit at Waterford General Hospital to assess their opinions on the services provided: one patient was of temporary status while the other two were voluntary. All patients had a positive attitude to the psychiatric services. They were pleased with the courtesy and helpfulness of the medical and nursing staff and with the frequency of their meetings with their consultant psychiatrist, which occurred on average three times weekly. Their psychological problems were fully explained to them as were their prescribed medications, although one patient would prefer literature on the latter. They were also pleased with the quality and quantity of food. They were satisfied with the standards of hygiene in the toilets and bathrooms. All patients had ample space for their personal belongings and were pleased with the laundry facilities available in the unit. Sleeping arrangements were also satisfactory. What appealed most to the three patients were the occupational arts and crafts and the recreational activities area. None of the patients felt there was a primary nurse responsible for their care nor were they aware of the concept of nursing care plans. When asked how they would like to see the service improved all agreed that, until they reached a stage of their recovery that would merit receiving their doctor's permission to leave the ward, they should have access to a safe garden area particularly in warm weather.

RECOMMENDATIONS

It is recommended that:

- 1. The patients resident in St. Enda’s ward be transferred to Grangemore until purpose-built accommodation becomes available.
- 2. The patients currently in St. Clare’s ward be transferred to Grangemore when it becomes vacant.
- 3. A multi-disciplinary rehabilitation team be established without delay to enable the first two recommendations to occur and for wider and continuing rehabilitation purposes.
- 4. Specialised teams be put in place to provide services for liaison psychiatry and for the intellectual disability service, this latter in association with the regional service of Belmont Park or independently.
- 5. Brook House become the mental health centre and acute day hospital for the Mid Waterford and South Kilkenny Sectors.
- 6. Suitable premises be acquired to function as a mental health centre and acute day hospital for the East Waterford Sector.
- 7. Additional social workers and psychologists together with occupational therapists be recruited to provide multi-disciplinary teams for the existing general adult teams and for the specialised teams recommended.

WEXFORD MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 3 APRIL, 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 116,596 was divided into four sectors as follows:

Sector	Population
Wexford	42,613
Enniscorthy	32,866
Gorey	20,470
New Ross	20,647

The Wexford Mental Health Service operated through in-patient care at St. Senan’s Hospital, Enniscorthy, and a range of community-based facilities and included a specialised later-life service.

IN-PATIENT CARE

In-patient care was provided at St. Senan's Hospital, which had 172 beds in four male, four female and three integrated units.

Age and Length of Stay of all Patients AT 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	13	9	7	2	31	19.5
3-12 Months	—	—	8	7	3	1	19	11.9
1-5 Years	—	—	8	6	10	10	34	21.4
> 5 Years	—	—	13	24	18	20	75	47.2
All Lengths of Stay	—	—	42	46	38	33	159	100.00
% of Total			26.4	28.9	23.9	20.8	100.0	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
1	51	1	26	5	14
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
1	9	2	28	21	159

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	73	56	129
Temporary	6	3	9
P.U.M.	10	9	19
Ward of Court	2	1	3
Total	91	69	160

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
617	5.3	167	27.1	89	11	620	19

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	24	600
Day Centres	2	61	99
Out-patient clinics	4*	286**	1,688

*No. of locations

**No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
7	26	5	32	2	23

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
12	15	164	88	5

COST

The cost of the Wexford Mental Health Service was €14.3 million in 2002.

GENERAL COMMENTS

The Inspectorate commented in the 2002 Report on the difficulties and tensions which existed among senior staff at St. Senan's Hospital, which, in their view, was seriously interfering with the planning and the development of the service. The Inspectorate regrets to report that little had improved at the time of Inspection. The lack of planning was reflected in the lack of progress in providing community-based facilities for the service.

One improvement in the service since 2002 was that the premises acquired at St. John's Hospital, Enniscorthy, a former two-storey convent, Carn House, had begun a limited operation with the later-life patients and was, in a limited way, serving as the headquarters of this service and provided a day facility for some elderly patients in the mornings only. Two general adult out-patient clinics were also held here, having been transferred from the unsuitable general health centre. At the time of this visit, (lunchtime), the elderly patients had departed and there was no further patient activity scheduled for the rest of the day despite the presence of staff. This was a fine premises with potential to serve as a sector headquarters, mental health centre and acute day hospital for the Enniscorthy sector. Its current confused and contrasting functions clearly illustrated the lack of planning and objectives of this service as a whole. General adult out-patients services should operate from the same premises as primary care services. Also, the later-life team should have its own autonomous headquarters and day hospital, preferably adjacent to a general hospital.

The other premises in this service with the potential to provide a comprehensive mental health centre/acute day hospital operation was the Summerhill premises in Wexford town. As the other two sectors, New Ross and Gorey, did not have any such premises, perhaps the Enniscorthy operation should serve North Wexford and the Summerhill centre serve South Wexford as mental health centres and acute day hospitals. Apart from two basic grade psychologists, there were no other allied health professionals employed in the service at the time of inspection. These deficiencies hampered the development of truly multi-disciplinary teams.

In 2002, the Inspectorate was happy to learn that five intellectually disabled patients attended St. Aidan's day centre in Gorey, on a daily basis and that this number would increase. However, it was disappointing to hear that this had not happened and that the number attending remained at five. Likewise, the Inspectorate was surprised to learn that the proposed residential premises at Oylgate for intellectually disabled patients in St. Senan's had not progressed.

The admission wards in St. Senan's Hospital were totally unacceptable for their function. The problems posed by these wards were compounded by the absence of the implementation of an admission policy. All the evidence available to the Inspectorate indicated that assessment and admission was mostly the task of junior doctors, who did confer with consultants in the matter. The result of a lack of suitable alternatives to inpatient care was many unnecessary admissions to St. Senan's Hospital. This led to the overcrowding of the two admission units, with the result that the numbers of inpatients almost always exceeded the number of beds on the wards. The totally unacceptable solution to this was the "sleeping out" of admission patients in other wards. The acute admission bed shortage was worsened by the number of long-stay patients for whom no appropriate accommodation or placement had been found. The most distressing aspect of all of this was that the provision of a modern acute admission unit in Wexford hospital seemed remote.

The specialised service for later-life psychiatry lacked resources. The skeleton of a multi-disciplinary team was being assembled but there was no social worker or occupational therapist. The temporary headquarters for this service was not satisfactory and, moreover, impeded the setting up in Carn House of a comprehensive service for general adult psychiatry for which the building was better adapted. Likewise, the lack of appropriate inpatient assessment and admission facilities, shared with the general service, pointed to the urgent need for such a resource in Wexford General Hospital.

Out-patient clinics were located at Enniscorthy, Wexford, Gorey and New Ross. An appointments system known to referral agents' ensured patients had a minimal wait for attendance at the Enniscorthy Health Centre. Specific appointment times were not given to patients at Gorey or New Ross, but new patients were seen first. There was a waiting list for out-patient consultation of 4-6 weeks. The Inspectorate was informed that people on the waiting list were prioritised according to need.

There were 64 involuntary admissions to St. Senan's in 2002 and a further two admissions of wards of court: one patient admitted as an involuntary patient was re-graded to voluntary status and one patient admitted as a voluntary patient was re-graded to involuntary

status during the course of their hospitalisation. There was one admission of a person aged less than 16 years. Three patients who presented for admission were lodged in the hospital overnight but not formally admitted. There were 19 deaths in St. Senan's in 2002, all from natural causes. In 2002, 14 patients took their own discharge from the hospital against medical advice. All patients were requested to sign a form indicating that they were taking their discharge against medical advice and were offered out-patient consultations if deemed clinically appropriate. Eight patients became new long-stay patients in St. Senan's Hospital during 2002 and five of those were aged 65 years or over.

There were 316 patients on the department of later-life psychiatry register at the end of 2002. Also, in 2002 there were 120 new referrals and 222 first referrals to this service. There were no specialised in-patient assessment beds. The team assessed patients in the St. Clare's and St. Brigid's admission unit and used beds in other wards of St. Senan's Hospital for continuing care.

During 2002, 13 patients were placed on special one-nurse to one-patient special nursing supervision and there were 346 duty spans of special nursing supervision. The policy and procedure on special nursing supervision should be reviewed and updated. Specific audit-able criteria for levels of observation and supervision should be developed and included in a hospital policy and procedure for the information of all staff.

In 2002, 22 patients were prescribed ECT at St. Senan's Hospital. There was a dedicated ECT suite and a named consultant psychiatrist responsible for the ECT clinics. The consent form in use was satisfactory. A new ECT checklist had been introduced since the last visit of inspection. Patients' vital signs were recorded pre-and at regular intervals post-ECT and this were very satisfactory. Whilst patients were physically examined prior to ECT, it was noted that one physical examination was undated.

There were 34 episodes of seclusion involving five patients in 2002. There was no agreed seclusion policy and procedure. A draft copy was produced by the ward staff in 2002 and submitted to management for ratification. A seclusion register was maintained satisfactorily and 15-minute nursing observations were recorded of all patients whilst in seclusion. Access to the seclusion room, which was adjacent to the smoking area, was just off a ward corridor and there was inadequate privacy for patients. All patients placed in seclusion should have an unrestricted view of a clock. There should be a multi-disciplinary review documented for each episode of seclusion within 12 hours of the seclusion episode. This should include the doctors and nurses views and information on patients' response to seclusion during and after the event appropriately documented.

There were no research projects governed by the Clinical Trials Act, 1987-1990 undertaken in the Wexford Mental Health Services in 2002. In 2002, 20 accidents to patients and 20 accidents to staff were recorded; none were deemed serious, 10 of the accidents to patients resulted in minor injuries. Also in 2002, 15 assaults on patients and 29 assaults on staff were recorded. Seven of the patient assaults and 16 of the staff assaults resulted in minor injury.

There were no complaints made by patients or patients' relatives to the local complaints manager last year. However, it was indicated to the Inspectorate that patients were constantly complaining about the lodging-out arrangements. There were eight requests for information under the Freedom of Information Act, 1997 and all appeared to have been dealt with satisfactorily. Written guidelines on the handling of complaints should be available in each treatment location and known to all staff members and available on request to patients and families. In addition, notices communicating this information should be prominently displayed in all inpatient areas. All staff working in St. Senan's Hospital should wear an identifying name badge stating their designation within the multi-disciplinary team.

A number of medical files were examined. There were written instructions on filing of documentation within the record. Whilst there was provision for the recording of the patient's name on each continuation page, this was not always recorded. Each newly-admitted patient had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and clear immediate management plan appropriately documented. On discharge, a patient was given a clinical card with the name of the prescribed medications, phone number of the hospital and appointment at out-patient clinic. This information should be in triplicate, one copy to the patient, one kept in the file and one sent to the professionals responsible for follow-up. The facilities at the clinics provide adequate privacy and confidentiality.

The health and safety statements were under review. Revised and updated health and safety statements should be available in each local area for staff information and reference. In addition to the health board generic safety statement, each unit should have a small individual safety statement appropriate to the unit. Records of periodic safety audits should be kept, highlighting identified hazards by level of risk and identifying the staff member responsible for ensuring appropriate action was taken to eliminate or minimise the identified hazards.

Fire precautions at the hospital were satisfactory. There were written fire orders and the newly-installed automatic fire detection system appeared to be working satisfactorily. The checking system to ensure equipment operated effectively in emergencies was recorded, dated and signed. There were regular fire drills and evacuation precautions and all were appropriately recorded.

A draft drug management administration policy dated 1st April 2003 had been introduced. This draft policy was comprehensive but required the signature of the clinical director, director of nursing and risk manager. The draft policy should be stored in the policy manual and kept separate from the safety statement. All prescriptions should be signed and dated individually and a drug administration recording card should have provision for the nurse's signature in full. There was an increased risk factor of drug error in a number of the long-stay wards, where discontinued prescriptions were greater in number than current prescriptions. The storage area and transport system between the units were satisfactory.

St. Senan's Hospital had written operational policies setting out how that service operated. However, there was virtually no written information available for patients on medications prescribed. There should be an annual review of the quality, efficiency and effectiveness of the service as a whole. This review should identify strengths and weaknesses in policies and programmes with a view to improvement and revision. Regular audits of different aspects of service provision, such as record-keeping standards and medication and prescribing patterns, should be conducted and reported on as part of the annual review. In addition, patients' and relatives' views should be used as a valuable reference tool when evaluating treatment. Management team meetings were not held frequently in this service. The last meeting was in October 2002.

As mentioned in previous reports, all patients in the long-stay wards of St. Senan's Hospital should be individually assessed for their future care and placement needs. On this inspection, it was noted in some wards that several policies, procedures and protocols were in place, some of which originated with the South Eastern Health Board while others were unit specific. It was noted that there was a lack of clarity on what constituted a policy procedure, protocol or guideline. Ideally, all policies, procedures and guidelines should have a multidisciplinary focus, be individually numbered, note the authors or point of referral, record the date of ratification, by whom ratified and have a review date and audit by date and detail responsibility for these. It should also detail when the policy had been superceded or was no longer to be considered valid. All revised and superceded policies, procedures and guidelines should be removed from operation. A predetermined number of copies should be retained for possible reference in the future. Draft policies should not be placed on operational policy files and any changes to policies should be dated and signed. All staff should be asked to sign that they have read, understood and intend to comply with the policy content.

New nursing care plan documentation had been introduced and a number of the care plans were examined as part of this inspection. The biographical datasheet for each admission recorded the patient's legal status, next of kin, name of GP, the patient's height, weight and temperature, pulse and respiration. Drug allergies, drug sensitivities, blood pressure and urine testing were not recorded. One of the biographical information sheets which was part completed for a patient failed to record the name of the primary nurse and was unsigned and undated. The standard of recording the psychiatric history, social history and medical history was variable. All entries in the nursing documentation should be accurately dated and timed using the 24-hour clock. Nursing assessments were completed satisfactorily and signed. Some nursing evaluations were not completed seven days post admission. Ideally, nursing records should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment. The nursing records contained relevant information relating to nursing observation of the patient and changes in the patient's condition.

Medical case-note documentation left much to be desired and was often hard to follow. Admission notes were not very informative with regard to the reasons for admission and whether alternatives to in-patient care were considered. Neither was there information as to whether a consultant had been involved in the decision-making. Detailed admission

assessments including an ICD diagnosis and a planned treatment programme involving the patient were usually missing. Most often, the subsequent medical entries were by junior doctors, even though the ward round or interview might have been carried out in the presence of a consultant. More seriously, the regular six-monthly physical examination of patients had often not been carried out. In all cases where a six-monthly extension of a detention order had been effected there were no case-note entries to indicate that this had happened, and more worryingly from a civil rights point of view, why such a restriction of civil liberty was thought necessary.

Three patients were interviewed to assess their views of the psychiatric services provided to them: all three were of voluntary status. While they had some reservations about certain aspects of the services, on the whole they were positive. All were very satisfied with the courtesy and helpfulness of the nursing and medical staff and with the privacy and dignity afforded them. All were pleased with the availability of their consultants and the privacy with which they could have consultations. However, one patient complained about not having a similar level of privacy when dealing with nurses. All patients were happy with the manner in which their psychological problems were explained to them and also the side effects of the medication. Two of the patients hadn't heard of nurse care plans and didn't understand the concept and neither did they comprehend the notion of a primary nurse being involved in their care. Two patients said they had not received any hospital handbook while one had received a leaflet. All were informed of their rights under the mental treatment legislation but none were aware of any complaints procedures. One patient had received input from a psychologist and was very pleased with this intervention. All of the patients appreciated the food presentation, the menu variety and the quality and quantity of food provided.

The main areas of concern to all three patients were the lack of hygiene and cleanliness in the toilets and bathrooms. All were of the opinion that a general refurbishment of the hospital would not go amiss.

RECOMMENDATION

It is recommended that:

The problems of planning, directing and managing this service be addressed at senior health board executive level as a matter of urgency. It was very disappointing that very little progress had been made despite urgent recommendations made last year in the realisation that the current difficulties had serious consequences for the quality of service provided to patients. As all other deficits in service delivery followed from this fundamental difficulty there appeared to be little point in making further individual recommendations at this time.

CHAPTER EIGHT

Southern Health Board

KERRY MENTAL HEALTH SERVICE — 2003 INSPECTION INSPECTED ON 1 and 2 JULY 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 132,527 was divided into five sectors as follows:

Sector	Population
Listowel	24,055
Tralee East/Dingle	28,024
Tralee West	26,475
Killarney	27,673
Kenmare/Cahirciveen/Killorglin	26,300

IN-PATIENT CARE

In-patient care was provided at St. Finan's Hospital, Killarney, which had 125 beds in four male and four female wards, and at the 50-bed acute unit, Tralee General Hospital. Community care was provided through a range of day-care and residential facilities in the county.

Age and Length of Stay of all Patients at 31.12.02 — ST. FINAN'S HOSPITAL, KILLARNEY AND ACUTE UNIT, TRALEE GENERAL HOSPITAL

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	1	4	13	16	7	7	48	28.0
3-12 Months	—	—	3	4	2	3	12	7.0
1-5 Years	—	—	4	5	6	4	19	11.0
> 5 Years	—	—	3	27	35	28	93	54.0
All Lengths of Stay	1	4	23	52	50	42	172	100
% of Total	0.6	2.3	13.4	30.2	29.1	24.4	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
9	98	—	13	13	2
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
4	15	—	15	3	172

**Status of In-Patients on date of Inspection 2003 — DEPARTMENT OF PSYCHIATRY,
TRALEE GENERAL HOSPITAL**

Status	Male	Female	Total
Voluntary	21	18	39
Temporary	4	7	11
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	25	25	50

Status of In-Patients on date of Inspection 2003 — ST. FINAN'S HOSPITAL

Status	Male	Female	Total
Voluntary	51	39	90
Temporary	8	6	14
P.U.M.	1	4	5
Ward of Court	5	5	10
Total	65	54	119

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
849	6.4	317	37.3	82.0	18.0	856	19

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	3	59	243
Day Centres	6	105	147
Out-patient clinics	8	305*	1,478

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
—	—	12	61	5	79

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
13.67	13.33	279	92.7	7.33

COST

The cost of the Kerry Mental Health Service was €13.9 million in 2002.

GENERAL COMMENTS

The plan for the closure of St. Finan's Hospital was presented to the Southern Health Board a short time before the Inspectorate's visit. The Inspectorate's understanding was that the plan was accepted in principle, but required clarification.

The proposal was that the main building and some surrounding land would be sold but the O'Connor unit would be retained. To facilitate this, alternative placement of the 85 patients in the old building would have to be effected. It was envisaged that, firstly, a 14-bedded high-support residence would be constructed. This process was already under way through the efforts of the Kerry Mental Health Association who had responsibility for the project, grant-aided by the Department of the Environment. When this building was completed the residents of Cherryfield high-support residence would transfer to it leaving the refurbished Cherryfield free to accept the 18 occupants of the two locked wards in St. Finan's Hospital, St. Peter's and St. Martin's, allowing these wards to close. Approximately four intellectually disabled patients would be transferred to residential accommodation provided by the Kerry Parents' and Friends' Association. Six or seven younger long-stay patients would be placed in existing community residences and a number of older persons would be placed in nursing homes. The remaining elderly patients would be placed either in the O'Connor unit or, in an expanded service for the elderly in conjunction with that unit. The envisaged time-scale for these moves was estimated to be two years from commencement.

The Inspectorate was happy to learn of this plan as conditions in St. Finan's Hospital were quite unacceptable. This was particularly true of the male wards St. Peter's, St. Paul's and St. Joseph's despite the welcome improvement in the two locked wards since they were moved downstairs. Conditions in Our Lady's ward, where staff were coping valiantly with very unsatisfactory conditions also exemplified the unsuitability of this old building to modern practice. However, the Inspectorate was told that a capital sum of approx. €150,000 had been set aside for remedying the worst of the physical defects before the move from St. Finan's Hospital began.

In contrast, the acute unit in Tralee General Hospital was functioning well. In 2002 it had been designated a district mental hospital for the reception of PUM patients to end the practice of these patients being admitted to St. Finan's Hospital. This had caused some staff anxieties because of the lack of close observation accommodation within the unit. A design team had been established to plan such an observation area and plans were being drawn up for a reception facility opening out to the back of the unit that would only be used for exceptional admissions. Routine admissions would continue to be processed through A & E. It would be helpful if, in conjunction with this initiative, a ward clerk were recruited. The design team was also addressing the matter of providing a new and more spacious occupational therapy premises.

While documentary procedures in the unit were generally satisfactory and those relating to ECT administration and medical progress notes were particularly impressive, some improvement might be effected in the patient intake assessment procedures. There was little written evidence that a formal multi-disciplinary intake assessment leading to an ICD diagnosis had taken place. Likewise, there was little evidence that there was a planned programme of treatment in which the patient and relatives participated.

There had been some changes and improvements in community facilities, such as the opening of the new community residence at Cahirciveen and the new entrance to the Killarney day hospital. This latter premises was somewhat small for an acute day hospital and consideration should be given to establishing a comprehensive sector headquarters and acute day hospital in Killarney on the model of the new Caherina premises in Tralee. The old Caherina house was still used for office purpose by the mental health services. The Inspectorate regretted that it could not be used for community residential purposes to help with the relocation of St. Finan's residents. However, it was noted that that the building was deemed unsuitable for residential use by Technical Services. A day centre was envisaged shortly for Kenmare. There was an evident and accepted need for more psychology and social work personnel.

The issue of acquiring sub-specialty services was under consideration and a post of consultant psychiatrist in later-life psychiatry had been progressed. There was an acknowledged requirement for a consultant-led rehabilitation service. Some specialisation in consultation/liaison psychiatry and in the psychiatric illness of intellectual disability was also needed for the county.

In 2002, 111 patients were admitted involuntarily to the Kerry Service, which represented 18 per cent of all admissions. As the national percentage of non-voluntary admission was 11 per cent, there was a need to examine the reasons for the high percentage of non-voluntary admissions to this service. Of the 111 involuntary admissions, 22 had been admitted as voluntary patients and re-graded to involuntary status during the course of the hospitalisation. A further ten patients admitted as involuntary patients were re-graded to voluntary status whilst hospitalised. Eleven patients in the service had their temporary reception orders extended during 2002. Eight patients were transferred from the Valentia and Reask wards to St. Finan's Hospital in 2002. Ten patients took their own discharge from the service against medical advice in 2002. Appropriate procedures were in place for follow-up of these patients.

There were 14 deaths in St. Finan's Hospital and five deaths at the Department of Psychiatry in Tralee General Hospital in 2002. There were seven complaints by patients or patients' relatives to the local complaint manager at St. Finan's Hospital in 2002 and nine requests were made under the Freedom of Information Act, 1997; all appeared to have been dealt with satisfactorily. There were no complaints or no requests under the Freedom of Information Act, 1997 made at the Department of Psychiatry, Tralee General Hospital. Staff had the responsibility of bringing to the attention of all patients the procedure for making a complaint through a local complaint system and, in relation to involuntary patients, their rights' under the Mental Treatment Act, 1945 and amending legislation.

There were no research projects governed by the Clinical Trials Act, 1987-1990 undertaken in the Kerry Mental Health Service.

There were 32 episodes of seclusion, involving eight patients in St. Finan's Hospital and 41 episodes, involving ten patients at the Department of Psychiatry, Tralee General Hospital during 2002. As mentioned in previous reports, the safe room in Tralee General Hospital was far from ideal; the room itself was not safe and more appropriate facilities were required. Seclusion authorisations were, for the most part, made by junior doctors. Some were counter-signed by a consultant psychiatrist. A seclusion register was appropriately maintained and nursing observations, as required under the Mental Treatment Act, 1945, were documented. There were plans to provide better observational facilities at this unit, which would include a safe room. A multi-disciplinary review should be completed and documented for each episode of seclusion, which should include the doctors', nurses' and patients' views of the seclusion episode. All patients whilst placed in seclusion should have an unrestricted view of a clock from the seclusion room.

There were 56 recorded accidents to patients and seven recorded accidents to staff at St. Finan's Hospital, all resulting in no detectable injury. There were 17 recorded assaults on patients by other patients, nine resulting in minor injury. There were 16 recorded assaults on staff, two resulting in minor injury. As mentioned in previous reports, a recording system should be in place at the Department of Psychiatry, Tralee General Hospital, to record accidents and assaults to patients and staff for inclusion in the annual statistical return. There should also be a regular scrutiny of the statistics by unit managers to provide analysis by time-of-day, geographic location, cause of accident, incident or assault and nature of injury. All of this should be included in a risk management strategy for the unit, as a whole.

Accidents, incidents and assaults should be categorised by grade of injury similar to the system in use in St. Finan's Hospital. The Inspectorate had recommended this in the past and was disappointed that such an important matter had not been addressed. Health and safety and safe-work practice standards were in draft form. There was no record of a local environmental safety audit. Written fire orders were appropriately displayed at all locations and the system of checking equipment to ensure it operated effectively in emergencies appeared satisfactory. Inspections of fire equipment and appliances were recorded, dated and signed.

The standard of hygiene of the food preparation area at Tralee General Hospital was satisfactory. However, the overall space provided was cramped. Some improvements were required in the physical environment of the dining area at this location. A printed menu should be available for patients. Patients and staff should have some input into any reviews of the menu cycle.

Seventeen patients were prescribed ECT at Tralee General Hospital in 2002. There was a dedicated ECT suite, including a separate waiting and recovery room. All documentation in relation to this treatment was completed satisfactorily. A named consultant psychiatrist was responsible for the ECT clinic. Appropriate records were kept in the clinical notes of

all discussions held with patients relating to the nature of this procedure. The physical examination prior to general anaesthetic was appropriately recorded. The patients' clinical status was assessed following each ECT treatment and the patients cognitive functioning was monitored on an on-going basis and at the end of each course of treatment. All of this was documented in the clinical notes and was satisfactory.

Since the last visit of inspection a number of policies, procedures and guidelines had been updated and circulated to staff for discussion. From a risk perspective it was necessary to have systems of implementation and audit of compliance of all policies, procedures and guidelines to enable risk reduction or elimination to occur. All new policies, procedures and guidelines should have a multi-disciplinary focus, be headed with a hospital or service title, be individually numbered, note the author, record the date of ratification and by whom, have a review date and audit-by date and detail responsibility for these. It was noted that the revised policies were, as far as possible, research based, referenced and the relevant authorities noted. Details should be recorded in the policy manual of which policies had been superseded or were no longer to be considered valid. A computerised index of all policy documentation which records date of ratification, implementation and review should be kept in a unit central file. All revised and superseded policies should be removed from operation, with a pre-determined number of copies retained centrally for possible future reference. Policies, once ratified should be formally introduced to relevant staff to ensure awareness and understanding of content. Staff should sign the policy manual to say that they have read, understood, intend to and are able to comply with policy content. It was gratifying to note that the service was drawing up policy, procedures and guidelines to suit their own local needs.

It was noted that staff were trained in the avoidance of violence and aggression and had in-service training sessions on clinical risk assessment. There appeared to be an active in-service education programme at the Department of Psychiatry, Tralee General Hospital and this was welcomed. A personal safety alarm at Tralee General Hospital had been upgraded since the last visit of inspection. All staff carried personal safety alarms which enabled a speedy response to be available to them in emergency. A policy on the use of the new personal safety alarm was available in draft form.

Newly-admitted patients had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and management care plan, appropriately recorded in the clinical notes. Written instructions on filing of documentation within the record were required. The patient's name should be clearly recorded on each continuation page. The person making the entry in the clinical notes should sign their name in full and record their designation within the multi-disciplinary team.

Nursing documentation was under review at the time of inspection and the service was moving away from the 'Roper' model of nursing to a new system with inputs from a number of nursing models. The new system, when implemented, will reflect the involvement of patients in planning and making choices and decisions about their own care and

treatment. All entries in nursing notes should be signed in full, with block lettering alongside the signature of the first entry. The signature should be accompanied by the status of the nurse.

The policy for the ordering, prescribing, storing and administration of medicines was under review and the service was changing to a new prescription card at the time of inspection.

A number of patients were interviewed to assess their opinion of the psychiatric services provided in order to highlight areas where the local service needed to make changes. All patients were satisfied with the courtesy and helpfulness of staff and with the admission process. However, one patient felt that some nurses were condescending towards him. All were introduced to their nursing team, especially their primary care nurse and had access to their consultant psychiatrist when required. They were informed about the nature of their medical condition, the medication prescribed and their side-effects etc. However, one patient was not informed about her rights under the Mental Treatment Act, 1945 or on how to make a complaint if she felt aggrieved. Patients were generally satisfied with all aspects of privacy and dignity relating to their care, access to and cleanliness of the bathrooms and sleeping arrangements. One patient expressed dissatisfaction with the quality of food provided. One patient was pleased with the ward activity on offer e.g. yoga, art and community walks. When asked how they would like to see the services improved one said he would like to have longer interviews with doctors. Another would like to see an improvement in the quality of the food provided.

RECOMMENDATIONS

It is recommended that:

1. The closure of St. Finan's Hospital be proceeded with as quickly as possible.
2. In the meantime some improvements be effected in the physical conditions in St. Joseph's, Peter's and Paul's wards together with Our Lady's.
3. Sector headquarters/mental centres in combination with acute day hospitals be established in the Killarney and Listowel sectors.
4. Additional psychologists and social workers be recruited.
5. Subspecialty services be established particularly in the fields of later life and rehabilitation.

NORTH CORK MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED 9 OCTOBER 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 73,511 was divided into three sectors as follows:

Sector	Population
Fermoy	25,024
Mallow	26,745
Kanturk	21,742

IN-PATIENT CARE

In-patient care was provided at St. Stephen's Hospital, Glanmire, which had 198 beds in nine integrated wards. Community services were very limited.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	9	7	5	—	21	11.2
3-12 Months	—	—	—	7	2	—	9	4.8
1-5 Years	—	—	8	10	8	6	32	17.1
> 5 Years	—	—	5	36	45	39	125	66.9
All Lengths of Stay	—	—	22	60	60	45	187	100
% of Total	—	—	11.7	32.1	32.1	24.1	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
10	105	—	38	6	1
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
4	7	1	13	2	187

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	106	72	178
Temporary	4	7	11
P.U.M.	—	—	—
Ward of Court	5	3	8
Total	115	82	197

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
364	5.0	106	29.1	93.1	6.9	374	12

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	25	44
Day Centres	4	44	151
Out-patient clinics	4	134*	768

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
4	16	—	—	1	14

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
10	19.2	181	74.76	10.83

COST

The cost of the North Cork Mental Health Service was €20.6 million in 2002.

GENERAL COMMENTS

St. Stephen's Hospital consisted of two main components, the two admission units and the remainder of the hospital which catered for elderly long-stay patients. The admission units were unsuitable for their purpose and should be replaced by an acute unit at Mallow General Hospital for the catchment area of North Cork. In the meantime, it was neither efficient nor judicious to keep the two admission units open; one should be closed and the staff deployed to community-based duties. More selective admission policies should make this possible, as well as reducing the number of transfers.

Apart from the admission units, there were approximately 160 patients in St. Stephen's Hospital; approximately two-thirds of them over 65 years and the majority from outside the North Cork service area. Most of them had been transferred from Our Lady's Hospital, following its closure. Some patients from other catchments were being admitted to St. Stephen's Hospital by agents and agencies other than the North Cork team — a practise that did nothing to help with the reduction of St. Stephen's numbers and its

ultimate closure given its fundamental unsuitability for modern psychiatric care. The Inspectorate was thankful that admissions from outside the Cork city area had ceased. The lack of a specialised rehabilitation service for younger patients was regretted. Also, the lack of alternative appropriate placements for elderly patients was evident; not that the care of the dependent elderly in units such as unit 2 was anything but satisfactory. However, the case for the de-designation of these units was unanswerable. There was neither a specialised later-life service in North Cork nor any specialised service in the psychiatry of intellectual disability for the entire Cork region.

The North Cork service had few community-based services, although some encouraging plans were evolving. These included the proposed high-support residential facility, incorporating a day centre in the grounds of St. Patrick's Hospital, Fermoy and a 14-bed residential facility plus 4 independent flatlets at Kanturk. A new house in Mallow, in association with the Mental Health Association opened in February 2003 and facilitated the transfer of some patients from Solus Nua. A new premises had been acquired to function as a sector headquarters for the Mallow Sector and would complement the existing facility there. A house in Glanmire was pending and while the community-based activities were operating on a five-day-week basis, community mental health nursing operated on a seven-day-week basis. Nonetheless, substantial further investment was essential to provide this service with adequate community-based facilities.

The clinical nurse specialist counselling service which commenced in 2001, continued to operate from an office base at St. Stephen's Hospital, although most of the clinical work was based in community facilities. The Inspectorate recommended that regular review of the operation of this innovative service be undertaken.

There were 25 temporary admissions to St. Stephen's Hospital in 2002, 13 male and 12 female: 13 patients admitted as involuntary patients were re-graded to voluntary status and 13 patients admitted as voluntary patients were re-graded to involuntary status during the course of their hospitalisation. During 2002, 11 patients admitted as involuntary patients had their temporary admission orders extended. One patient admitted to St. Stephen's Hospital was aged less than sixteen years. Ten patients were transferred from St. Stephen's Hospital to other psychiatric in-patient services; four to the Carraig Mór unit, two to St. Michael's unit, Mercy Hospital, two to unit GF, South Lee and two to Limerick Regional Hospital. Eight patients were transferred from the admission units to long-stay units within St. Stephen's Hospital during 2002 and 12 patients became new long-stay patients; most of those were transfers from the former Our Lady's Hospital. There were twelve deaths in St. Stephen's Hospital in 2002, all from natural causes. In 2002, 24 patients took their own discharge against medical advice and all were offered out-patient appointments for follow-up, if deemed clinically appropriate.

There were 197 accidents to patients and eight accidents to staff in 2002: six of the accidents to patients and one of the accidents to staff were deemed serious. The reporting system relating to accidents and incidents was satisfactory. There were 28 assaults on patients by other patients and 22 assaults on staff: none were deemed serious.

In 2002, there were 12 complaints and 21 requests under the Freedom of Information Act, 1997: all appear to have been dealt with satisfactorily. There were no research projects governed by the Clinical Trials Act, 1987-1990 undertaken in St. Stephen's Hospital.

Seclusion was not used in this service. In 2002, 53 patients were placed on one-nurse to one-patient special nursing supervision and there were 901 duty spans of special nursing supervision involving duty hours of ten hours or more. Special nursing supervision was initiated and discontinued on the instructions of a medical officer. The poor observation facilities at the admission unit accounted for some of the special nursing supervision. However, its use was costly and should be reviewed. The policy and procedures on special nursing supervision should be reviewed and updated and the service should consider introducing a system of prescribed recorded observation which can, for selected patients, be used as an alternative to one-nurse to one-patient special nursing supervision.

Nine patients were prescribed ECT in 2002 and all documentary procedures were completed satisfactorily. The facilities for ECT were not ideal as there was no separate waiting room or recovery room. Nevertheless, privacy was provided for patients when this treatment was in progress.

The revised information booklet for patients and relatives, which contained information on the local complaints procedure, hospital charges and on the rights of hospitalised patients, was widely available. An entry should be made in the patient's nursing or clinical documentation that this information had been given, with an indication of the patient's understanding.

The policies and procedures were last reviewed in 1996 and required immediate updating. The setting up of a local policy review committee would ensure regular reviews of policies. Revised policies should record the names of the authors, references used and should be introduced to relevant staff.

The health and safety statement examined in local units was undated. A site-specific safety statement was not available. As staff working within the health care sector can face many risks at work, a compendium of information on a range of health and safety issues within the workplace was available for information and reference. The multi-disciplinary Health and Safety Committee which met every two months should develop a local risk management strategy.

The Inspectorate welcomed a survey of patients' and family members' views as part of the discussion leading up to the production of the strategy document entitled "Focussing Minds". This emphasised the Southern Region's view that patients' views were a valuable reference tool when evaluating care. In this regard, the Inspectorate welcomed the introduction of an advocacy service across the region. The information guide to adult mental health services in Cork and Kerry set out a range of mental health services available within the region. This facilitated patients in accessing the appropriate services and provided contact details of a number of relevant voluntary and support groups.

Each unit within St. Stephen's Hospital had a written statement of purpose and function that accurately described what the unit set out to do and the manner in which care was provided. The day-to-day operation of each unit reflected the statement of purpose and function.

The patient assessment forms were generally well completed in all notes examined. Newly-admitted patients to St. Stephen's Hospital had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination, formulation, diagnosis and differential diagnosis and plan of treatment. There was provision for the recording of the patient's name on each continuation page of the clinical notes but this was not always recorded. The signature of the professional making an entry in clinical notes should record their name in full and state their designation within the multidisciplinary team.

During 2002, 154 new patients attended out-patient clinics. Out-patient clinics were held at four locations within the catchment area but the out-patient facilities at three of their locations were less than satisfactory. At O'Brien Street, Mallow the sound proofing was poor, resulting in difficulties relating to confidentiality between patient and doctor. Space at the Charleville clinic was limited: an alternative unit was available at Charleville but funding was required to bring it up to the appropriate standard. The out-patient clinic at Kanturk was held at the local day centre which had to close on clinic days; this was not satisfactory.

The service was in the process of changing to a new nursing care plan using the 'Tidal' model of nursing. This system, which reflected the involvement of patients in planning and making choices about their own care and treatment, was in its infancy and it was therefore not possible to comment on its effectiveness. Nevertheless, staff at this hospital appeared happy with its implementation. The biographical data sheet for each admission and the assessment details were all comprehensively completed in the notes examined. There was provision for recording patient's views about their illness and treatment plan and the patients were asked to sign their own nursing care plan, this system was being introduced in mental health services across the southern region. The nursing records contained relevant information relating to the nursing observation of patients; all were accurately dated but should be timed using the 24-hour clock.

The medical preparations policy required review and updating. The standard of prescription writing was variable. Written instructions on the use of prescription cards were required and should be included within the revised policy. There was provision for the recording of drug allergy, or drug sensitivity so that information was rapidly available to staff. However, this was not always recorded. On a number of prescription cards examined, it was noted that the discontinued prescriptions were greater in number than current prescriptions. As this may cause an increased risk of incorrect drug administration, all of these cards should be rewritten.

Two female patients at the admission unit were interviewed to assess their opinions of the services provided: one patient on her first admission. Both were pleased with the admission procedure at the hospital. They were satisfied with the courtesy and helpfulness of

staff, were introduced to the professional team responsible for their care and knew the name of their consultant psychiatrist. Both were happy with the frequency of consultation with their consultant psychiatrists. One patient preferred group consultations while the other patient favoured one-to-one consultations-both were facilitated. The nature of their illness had been fully explained to them as had the possible side effects of their prescribed medication. However, one patient would have appreciated written information on these matters. While both were happy with the nursing care provided, one felt that some nursing staff were too busy with administration. She would like more personal contact with them. One patient was unaware of the 'Primary Nurse System'. Neither patient was aware of the complaints procedure. One patient did not get a hospital information booklet, although these were readily accessible in the unit. However, her attention had not been drawn to them. Both patients found the therapeutic activities very helpful. However, both would like more patient activities in the unit, as the occupational therapy unit was some distance from the ward. Both were pleased with all aspects of hygiene in the unit. When asked how they would like to see the services improved, one patient said she would appreciate more personal contact with the nursing staff; the other patient would like more activities, therapies, games etc. to be provided to alleviate boredom in the evenings and at weekends.

RECOMMENDATIONS

It is recommended that:

1. The community services of North Cork be significantly expanded.
2. An acute admission unit at Mallow General Hospital be established.
3. Admission rights to St. Stephen's Hospital be restricted to the consultants of the North Cork team.
4. Specialised teams be recruited for later-life and rehabilitation psychiatry.
5. The policy and procedure relating to prescribed medical products be reviewed and updated.
6. Out-patient facilities at a number of locations be brought up to standard to ensure appropriate confidentiality for patients.
7. One admission Unit at St. Stephen's Hospital be closed and the staff deployed to community facilities.

NORTH LEE MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 8 OCTOBER 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 156,036 was divided into five sectors as follows:

Sector	Population
City North West	28,973
City North East	26,161
Cobh/Glenville	35,834
Macroom/Blarney	33,634
Midleton/Youghal	31,434

Carraig Mór, which forms part of the North Lee Mental Health Service, is reported on separately.

IN-PATIENT CARE

In-patient care was provided at the 50-bedded St. Michael's acute unit at the Mercy Hospital, and at Owenacurra which had 33 beds. Community Services were provided at a number of locations in the catchment area.

Age and Length of Stay of all Patients at 31.12.02 — ST. MICHAEL'S UNIT AND OWENACURRA

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	6	12	5	2	26	31.7
3-12 Months	—	1	7	11	2	2	23	28.1
1-5 Years	—	—	2	3	2	—	7	8.5
> 5 Years	—	—	—	8	11	7	26	31.7
All Lengths of Stay	—	2	15	34	20	11	82	100.00
% of Total	—	2.4	18.3	41.5	24.4	13.4	100.00	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	24	—	30	4	1
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
2	3	—	—	18	82

Status of In-Patients on date of Inspection 2003 — ST. MICHAEL'S UNIT

Status	Male	Female	Total
Voluntary	17	22	39
Temporary	5	4	9
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	22	26	48

Status of In-Patients on date of Inspection 2003 — OWENACURRA

Status	Male	Female	Total
Voluntary	15	15	30
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	15	15	30

ADMISSIONS/DISCHARGES AND DEATHS IN 2002 — ST. MICHAEL'S UNIT AND OWENACURRA

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
918	5.9	595	64.9	89.2	10.8	920	2

*Per 1,000 population

COMMUNITY FACILITIES**Day Facilities**

	Number	No. of Places	No. of persons attending
Day Hospitals	4	52	993
Day Centres	2	60	76
Out-patient clinics	10	473*	6,910

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
1	2	1	2	4	49

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
17	12	194	38.65	12.25

COST

The cost of the North Lee Mental Health Service was €9.25 million in 2002.

GENERAL COMMENTS

This service was the most developed of the four Cork catchment area services in both its community and acute admission components, with the latter being the only satisfactory unit in the four services. Nevertheless, this service was far from having all the necessary human and physical resources required for its five sectors. In particular, the lack of acute day hospitals/sector headquarters/community mental health centres was obvious, despite new day centre premises in Macroom and Cobh. However, a site had or was about to be acquired for a day hospital/day centre at Middleton. The Mental Health Association was co-operating in acquiring a premises at Blackpool. Meanwhile, the community residence at this location had been temporarily vacated because of the fire at the Sunbeam factory and patients were accommodated at St. Stephen's Hospital but would move back shortly as the house had not been damaged; only water and electricity supply had been interfered with.

There were no specialised services for the later-life psychiatry, for rehabilitation nor for the psychiatric illness of intellectual disability and services for children and adolescents were quite limited.

The Owenacurra Centre at Middleton, which had 20 admissions for respite care in 2002, functioned as a large-scale, high-support community residence but was still registered as an approved premises, despite the Inspectorate's repeated recommendations that it be de-designated. It should not be formally regarded as an in-patient psychiatric unit; patients could be taken in for respite care without the necessity of formal admission. The refurbishment of the Owenacurra Centre and the re-modelling of the internal layout and provision of enhanced furnishings and décor met patients' individual and collective needs in a comfortable and homely way. Once this unit was de-designated, a written information pack should be provided for residents, including information on the terms and conditions of residency. The rights and obligations of residents and staff should be clearly stated. Each resident should have a detailed care plan. A plan should also be in place to relocate some of the residents from the Owenacurra Centre to more appropriate small scale community-based accommodation.

There were 84 involuntary admissions to the St. Michael's Unit in 2002: all were admitted on temporary certificates. In 2002, 32 patients admitted as involuntary patients were re-graded to voluntary and 24 patients admitted as voluntary patients were re-graded to involuntary status. There were eight extensions of involuntary admission forms in 2002. Of the 767 discharges, 19 patients took their own discharge against medical advice and appropriate follow-up procedures were in place.

During 2002, 30 patients were placed on one-nurse to one-patient special nursing supervision and there were 548 spans of special nursing supervision involving duty hours of ten hours or more in the North Lee Service including Carraig Mór.

Four patients were prescribed ECT in 2002: all documentary procedures were satisfactory. A named consultant psychiatrist was responsible for the ECT clinic and the induction of junior doctors. There was a dedicated ECT suite comprising waiting, treatment and recovery areas. As the patients who were prescribed this treatment had been discharged from the unit it was not possible to check their clinical notes. The Inspectorate was informed that clinical status was assessed following each ECT session. Cognitive functioning was monitored on an on-going basis and at the end of each course of ECT treatment.

There were 12 recorded accidents to patients and two recorded accidents to staff in 2002; one of the accidents to patients was deemed serious. Of the three recorded assaults on patients by other patients and the 21 recorded assaults on staff, one staff assault was deemed serious. There were 163 liaison consultations at the Mercy Hospital in 2002, which resulted in 17 patients being admitted to the St Michael's Unit and a further 66 being referred to the mental health service out-patient department.

There were no research projects governed by the Clinical Trials Act, 1987-1990 undertaken in the North Lee mental health service. There were 11 complaints made by patients or patients' relatives to the local complaints manager; all appear to have been dealt with satisfactorily.

The medicinal products policy was under review at the time of inspection. Written instructions for use of prescription cards were required. In a number of cards examined, there was a high risk of incorrect drug administration to patients because discontinued prescriptions were greater in number than current prescriptions. There was some difficulty in interpreting which drugs had been discontinued because the discontinuation column had not been completed. The drug-recording card had provision for recording the initials of the nurse administering the drug, with a corresponding sheet with a signature bank to enable easy identification of the nurse. It was noted that only 13 nurses had signed the signature bank: a more robust system was required to ensure all professional staff complied with the drugs policy and procedure. While provision was made for the recording of drug sensitivities/drug allergies on the nursing notes in notes examined, this was not always recorded. User-friendly written information on prescribed medicines should be made readily available to patients and to patients' relatives.

The biographical cover sheet of medical records examined was not well completed. The headed paper at the St Michael's Unit should use the title St. Michael's Unit, Mercy Hospital and not Our Lady's Hospital, Lee Road. Written instructions on filing of documentation within the record were required. The record folders examined had open pockets with storage of loose clinical material: this can result in lost or misfiled information and delays in accessing pertinent information. The medical evaluation, including comprehensive admission notes, mental state examination, physical examination and immediate management plan were clearly documented in notes examined. Evidence of multi-disciplinary evaluations and coded ICD diagnostic formulations should be recorded.

A quality assurance programme should be initiated with a local committee to develop local policies, procedures and guidelines and a small steering committee to oversee implementation. This should involve local management reviewing different aspects of service

provision and providing feedback to staff on the performance of their unit. In this regard, a strategic plan should be put in place, setting out service objectives. This had been addressed to some extent in the 'Focussing Minds' document. Policies and procedures should be headed with the hospital title, individually numbered, the date of ratification and by whom recorded and an appropriate review and audit date. Once ratified, revised and superseded policies should be removed from operation and a small number retained in a central file for future reference.

Because of its location on the first floor, the Mercy Unit had a problem with access to fresh air for patients. There was a need to develop a secure outside area and ensure adequate availability of nursing staff to accompany patients who could not be allowed unescorted leave.

The Southern Health Board safety statement was revised and updated in 1998 and there was a site-specific safety statement at the Mercy Hospital. Safety audits which included an evaluation of the adequacy of existing arrangements were in place. The system for reporting incidents, accidents and assaults appeared satisfactory; all staff were aware of, and had been trained in, the reporting mechanisms. All staff in this service wore identifying name badges indicating their designation within the multi-disciplinary team. There was a system in place for informing patients of hospital charges.

There was a notice informing patients of their rights under the Mental Treatment Act, 1945, prominently displayed in inpatient care areas: the provision of this information should be recorded in the patients' case notes. While patients were informed about diagnosis, expected benefits/risks and known effects of any proposed treatment, a note of the explanations given should be recorded in the notes.

A new model of nursing known as the 'Tidal' model was in the process of being introduced and a new care-plan manual had been introduced which offered advice to nursing staff on appropriate interventions. Some patients had been assessed using the new model, for other patients, the older model was still in use. The 'Tidal' model reflected the involvement of patients in planning and making choices and decisions about their care and treatment. The up-to-date biological data sheet for each admission was appropriately recorded. There was a section for recording allergies/drug sensitivities; this was not always completed. If there were no known drug allergies/drug sensitivities this should be recorded, otherwise, it might be assumed that this was not considered. While all entries in the nursing documentation were accurately dated, time of entry should be recorded using the 24-hour clock. All entries should be signed in full using block lettering alongside the signature of the first entry. The signature should be accompanied by the status of the nurse.

Two patients, one male and one female, at St Michael's Unit, Mercy Hospital were interviewed to assess their opinions of the services provided: both were of voluntary status. Both patients were satisfied with the admission process and with the courtesy and helpfulness of staff. However, one patient felt that her consultant psychiatrist and the nurses did not spend adequate time in consultation with her. The second patient was satisfied with the frequency of his consultations with his consultant; he appreciated one-to-one

consultations. The primary nurse system operated on the unit and both patients knew the name of their primary nurse. One patient was not aware of any care plan. Both patients were unaware of their rights under the Mental Treatment Act, 1945, or the complaints procedures. However, these were printed and prominently displayed in the unit. Both patients were happy with the therapeutic activities available during the day, but found the evenings and weekends boring.

Both patients had been given information about their psychological problems and the prescribed medications have been fully explained to and understood by them. One patient, however, would appreciate getting written information on same. When asked for suggestions on how the services should be improved, one patient said she would appreciate more contact with the nursing staff and more in-depth consultations with her consultant psychiatrist.

RECOMMENDATIONS

It is recommended that:

1. Two consultant-led rehabilitation teams be appointed to the North Lee service, one with responsibility for Carraig Mór.
2. The Owenacurra residential unit at Middleton be de-designated.
3. Sector headquarters, day hospital and community health facilities be developed within each sector.
4. Outdoor space be provided for patients at St. Michael's Unit, Mercy Hospital.
5. Coded ICD diagnostic formulations be recorded in the case notes.
6. A steering group be established to review and update all clinical policies, procedures and guidelines.

OUR LADY'S HOSPITAL -CARRAIG MÓR — 2003 INSPECTION

INSPECTED ON 8 OCTOBER 2003

IN-PATIENT CARE

In-patient care was provided at Carraig Mór which had 42 beds.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	3	2	1	—	6	16.2
3-12 Months	—	—	—	3	—	—	3	8.1
1-5 Years	—	—	7	12	—	—	19	51.4
> 5 Years	—	—	4	—	5	—	9	24.3
All Lengths of Stay	—	—	14	17	6	—	37	100.00
% of Total	—	—	37.8	46.0	16.2	—	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
1	9	2	12	6	—
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
3	1	1	—	2	37

Status of In-Patients on date of Inspection 2003 — CARRAIG MÓR

Status	Male	Female	Total
Voluntary	18	10	28
Temporary	5	4	9
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	23	14	37

Statistics on staffing and the cost of this service are included in the Report on the North Lee Service.

GENERAL COMMENTS

Carraig Mór was being used for two purposes; for patients perceived by staff in the admission units of St. Stephen's Hospital as being too difficult or troublesome to manage there and to accommodate patients when there were no vacant beds in the acute units. There had been at least one transfer to Carraig Mór from these locations every second day during 2002. These transfers had been effected without reference to the procedures as laid down in the Mental Treatment Act, 1945. Involuntary transfers should have been effected

under Section 206 of the Act. This had not been done. The correct procedure for voluntary patients was that they should be discharged from the units to which they had been admitted and re-admitted as voluntary patients to Carraig Mór; voluntary patients cannot be transferred from one district hospital to another or to an authorised institution and the practise of transferring them from one unit to the other without prior discharge and readmission was irregular. These irregularities were pointed out to the staff we encountered on this inspection. There was little or no documentary evidence that patients had been informed of their purported transfer, the reason for it and the nature of Carraig Mór itself. It would be the Inspectorate's view that the decision to transfer a patient to Carraig Mór should rest with the appropriate consultant and should in no circumstances be because of bed shortages in the acute units.

The manner in which care was delivered to patients at Carraig Mór was illogical and confusing. As far as the Inspectorate could ascertain three elements were involved; each of the four catchments, or their clinical director rotated administrative responsibility for Carraig Mór on an alternating cycle, with clinical input during the working day being provided by their particular catchment area and out-of-hours care provided by the North Lee service. None of the medical care being delivered came from the specialist teams required for these two types of patients, forensic and rehabilitation. In this context, the Inspectorate were informed that a decision had been made in principle, and the matter had gone to Comhairle na nOspidéal, to appoint a forensic consultant psychiatrist to Carraig Mór with other responsibilities including to Cork prison. If this was the case then, this represented progress in the current totally unsatisfactory situation. However, it was quite clear that there was also an undeniable requirement for a consultant-led rehabilitation team.

Of the 90 involuntary admissions to the Carraig Mór unit in 2002, seven were re-graded to voluntary status, one patient admitted as a voluntary patient was re-graded to temporary after admission. In 2002, 112 patients were transferred from the Carraig Mór Unit to the other psychiatric in-patient services; 19 went to St. Stephen's Hospital, 74 to Cork University Hospital, eight to Bantry General Hospital, four to psychiatric services outside of Cork and the remainder to residences at Millfield House, Upton, Western Road and Skibbereen.

RECOMMENDATIONS

It is recommended that:

1. A consultant-led forensic team be appointed to take charge, *inter alia* of the Intensive Care unit.
2. Appropriate rehabilitation services be put in place for the patients currently located on the top floor of Carraig Mór.
3. The correct procedures for transferring and admitting patients to Carraig Mór be followed.

SOUTH LEE MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 8 OCTOBER 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 167,479 was divided into six sectors as follows:

Sector	Population
City South-East	28,538
City South-West	25,577
Bandon/Kinsale	29,184
Bishopstown	20,175
Ballincollig	17,489
Douglas/Carrigaline	49,516

IN-PATIENT CARE

Acute in-patient care was provided at the Department of Psychiatry, Unit GF, Cork University Hospital (CUH), which had 46 beds. Continuing care was provided at St. Finbarr's Hospital, where 44 beds were provided in one male, one female and two integrated units. Community Care was delivered through locally based facilities. Specialist services were now in place for liaison psychiatry and for the elderly.

Age and Length of Stay of all Patients at 31.12.02 — CORK UNIVERSITY HOSPITAL AND ST. FINBARR'S HOSPITAL, CORK

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	25	15	4	2	46	49.0
3-12 Months	—	—	5	5	1	—	11	11.7
1-5 Years	—	—	3	15	4	2	24	25.5
> 5 Years	—	—	3	6	3	1	13	13.8
All Lengths of Stay	—	—	36	41	12	5	94	100
% of Total	—	—	38.3	43.6	12.8	5.3	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
1	44	9	21	7	—
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
2	3	3	4	—	94

Status of In-Patients on date of Inspection 2003 — CORK UNIVERSITY HOSPITAL AND ST. FINBARR'S HOSPITAL, CORK

Status	Male	Female	Total
Voluntary	27	41	68
Temporary	10	5	15
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	37	46	83

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
658	3.9	182	27.7	77.5	22.5	661	4

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	2	45	629
Day Centres	1	15	61
Out-patient clinics	10	713*	3,305

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
6	21	—	—	2	20

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
21.89	9.84	101	6.46	9

COST

The cost of the South Lee Mental Health Service was €9 million in 2002.

GENERAL COMMENTS

There were serious deficiencies in this service as a result of very little development during recent years. However, it had been sectorised and there were plans to provide an outreach service for two of the Cork city sectors. In addition, an enhanced role for community-based provision from the new mental health resource centre at Ballincollig was planned and a more community-oriented and acute role was envisaged for the Ravenscourt day

facility in St. Finbarr's Hospital. Additionally, there were plans to reduce and, eventually, eliminate the practise of persons coming indiscriminately to unit GF for assessment with deviation to community facilities or the A&E. This process would be greatly facilitated by the arrival of the newly-appointed liaison consultant psychiatrist and team. Apart from the Bandon day centre, the Ballincollig mental health resource centre and the Ravenscourt day hospital, there was virtually no other community facility available to this, the largest of the Cork catchment areas. Obviously, it would take some time to put the community elements in place in all sectors, as well as augmenting the multi-disciplinary nature of sector teams.

The difficulties associated with the GF unit design would be more difficult to overcome. Significant capital allocation was essential to bring this unit up to acceptable standards and, in particular, to eliminate the highly unsatisfactory and irregular practise of sending persons to the locked Carraig Mór unit. Essential to this, was the provision of a close observation area with at least one safe room. Such improvements would require a sub-unit for acute assessment purposes for the later-life service. As matters stood, this newly-created service had a headquarters in premises near the Kinsale roundabout in the city, but apart from Ravenscourt, no day hospital and limited access to continuing care accommodation.

The lack of a specialised service for rehabilitation psychiatry for this, as for all other services in Cork hardly needed restating. The Inspectorate was happy to see that a form for acute evaluation of patients presenting to the unit had been designed and was completed for all such presentations. However, general case note redesign was badly needed and, in general, documentary procedures required considerable attention as highlighted in the 2002 report. Adequate evaluations of a multi-disciplinary nature and detailed care programme planning with patient participation were required as was documented information as to whether the assessing junior doctor had consulted with a consultant colleague. South Lee had the lowest admission rate in the Southern Health Board, the lowest number of in-patient beds per head of population and the least well developed community services in the Southern Health Board.

There were 145 temporary admissions to Cork University Hospital and a further three to the St. Catherine's Unit, St. Finbarr's Hospital in 2002; 116 patients admitted as involuntary patients were re-graded to voluntary status and 33 patients admitted as voluntary patients were re-graded to involuntary status following hospitalisation. There were two extensions of involuntary admission orders during 2002. Also, in 2002, 19 patients were referred from the Department of Psychiatry to the designated units at St. Finbarr's Hospital and a further six were discharged to the Glenmalure Hostel, Blackrock Road, Cork; nine patients were transferred from Unit GF to other in-patient services outside the catchment area, three were discharged to the St. Michael's Unit, Mercy Hospital, 3 to Dublin private hospitals, one to Waterford, one to St. Raphael's, Youghal and one to the United Kingdom. In 2002, there were 207 admissions to the Carraig Mór intensive care facility, 92 were transferred from the South Lee mental health service.

In 2002, 34 patients took their own discharge from Unit GF against medical advice. Procedures were in place to follow up those patients if deemed clinically necessary.

There were 11 complaints made by patients or patient's relatives and 29 Freedom of Information requests made to the local complaints/appeals manager during 2002. There were no research projects governed by the Clinical Trials Act, 1987 — 1990 undertaken in the service.

In 2002, 12 patients were prescribed ECT at Cork University Hospital. All arrangements, including the consent form for ECT were satisfactory: a named consultant psychiatrist was responsible for the ECT clinic and the induction of all junior doctors. Prior to the completion of the consent form, medical practitioners confirmed that they had explained to the patient the nature and purpose of this treatment.

Information notices on patients' rights and on the local complaints procedure were prominently displayed in inpatient care areas. However, it was not clear if these were brought to the attention of patients. All patients irrespective of their hospital status should be informed of their rights. The service should establish a system to ensure that information relating to patient's rights was properly recorded in the patient's case notes.

There were 100 recorded accidents to patients and four recorded accidents to staff in the South Lee mental health service in 2002; none were deemed serious. There were four recorded episodes of self-inflicted injuries; none were deemed serious. There were 11 recorded assaults on patients by other patients and 13 recorded assaults on staff: ten resulted in minor injury, none were deemed serious.

A number of clinical files were examined. Written instructions on filing of clinical documentation within the medical record were available. Inputs were recorded relating to the medical evaluation, mental state examination, physical examination and clear immediate management plan for each admission. The patient's name and hospital record number was not always recorded on continuation pages and there was storage of loose clinical material within files examined.

New prescription cards had been introduced since the last visit. All prescriptions were signed and dated individually, as were discontinued prescriptions. The drug administration recording card had provision for the nurse's signature in full. The standard of prescription writing was generally satisfactory indicating a very low risk factor of incorrect drug administration.

A new consultant psychiatrist-led liaison consultation service had commenced at Cork University Hospital, consisting of one consultant psychiatrist, three nurses, one psychologist, one social worker and a secretary. All were newly-approved posts and not all had been filled at the time of inspection. Comprehensive records need to be kept of all liaison consultations as statistical data for 2002 was not available.

In 2002, 27 patients were placed on one-nurse to one-patient special nursing supervision and there were 645 episodes of special nursing supervision involving duty spans of ten hours or more. The nursing documentation contained a statement in the nursing assessment giving a physical description of the patient and the biographical data sheet for each

admission was appropriately recorded and up-to-date. All inputs in the nursing notes were accurately dated; time of entry should be recorded using the 24-hour clock.

There were 71 first referrals to the newly-established Department of Later-life Psychiatry during 2002. Statistical data relating to the outcome of these referrals was not available. This service does not have dedicated in-patient assessment beds and there was no dedicated day hospital or day centre. Local service policies, guidelines and protocols specifying the procedures to be followed in providing care in defined situations were dated 1996 and were all under review at the time of the visit. Revised policies, procedures and protocols should be formally introduced to relevant staff in order to ensure awareness and understanding of content.

The Southern Health Board commissioned the Irish Advocacy Network to undertake work on its behalf in relation to a review of local services. Prior to the production of the strategy entitled “Focussing Minds”, 163 in-depth interviews were held with service users and feedback was included in the consultation document. The South Lee mental health service had a customer focus desk geared to meeting with patients to inform them of the patients’ charter and other matters pertinent to their stay in hospital.

The management team of this service met on a monthly basis and formal minutes were kept. A training day had been arranged in relation to setting up an audit programme. Audits of medication patterns, non-attendees at out-patient department and on certification had commenced. At St. Monica’s Unit, the health board safety statement dated August 2001 was available for staff information and reference. An outline of a health and safety inspection check list was available but no records of recent safety audits were kept locally.

The service was changing to a new nursing model known as the ‘Tidal’ model with a view to involving patients more in their own care and treatment. Adequate training should be provided for staff in relation to the implementation of this new system which may have to be amended to meet local circumstances.

Two patients, one male and one female, were interviewed to ascertain their opinions on the services provided: both were of voluntary status and on their first admission. Both were satisfied with the admission procedure; they had been introduced to their therapeutic team and were shown around the unit. Both were pleased with the helpfulness and courtesy of the nursing staff, knew the name of their primary nurse and their consultant psychiatrist. However, one patient would like to have had more one-to-one consultations with her psychiatrist rather than multi-disciplinary team meetings. The other patient had not met his consultant psychiatrist who was on vacation at the time of his admission. One patient would like more information about her psychological problems and about her prescribed medications. The sleeping arrangements were quite satisfactory and both patients very happy with all aspects of privacy and dignity in relation to their care. They had adequate storage space for personal belongings. One patient was unhappy with the cleanliness of the toilet and bathroom facilities. One patient was pleased with the ward activities provided, such as relaxation techniques, massage and the occupational therapies

such as art, cooking etc. However, both patients found the evenings and weekends boring because of the lack of appropriate activities.

The Inspectorate was satisfied that the cramped conditions of the unit contributed to patient boredom. This unit needed to be vastly expanded to allow ample room for patients, therapists and therapies.

RECOMMENDATIONS

It is recommended that:

1. There be considerable expansion of community-based services in the South Lee service.
2. Unit GF be re-designed to take account of the requirements as set out in the body of this report.
3. The practise of transferring patients to Carraig Mór be curtailed by adhesion to a strict admission policy for unit GF and, when this was unavoidable, transfers to be made formally under Section 206 of the Mental Treatment Act, 1945, in the case of detained patients and in the case of voluntary patients, the discharge of that patient from the unit and his/her re-admission voluntarily to Carraig Mór.

WEST CORK MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 1 JULY 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 50,803 was divided into two sectors as follows:

Sector	Population
Skibbereen/Clonakilty	27,239
Bantry/Dunmanway/Schull/Castletownbere	23,564

IN-PATIENT CARE

In-patient care was provided at the 18-bed acute psychiatric unit in Bantry General Hospital. Community Services were provided at a number of locations in the catchment area.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	4	2	3	—	9	82
3-12 Months	—	—	1	1	—	—	2	18
1-5 Years	—	—	—	—	—	—	—	—
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	—	5	3	3	—	11	100
% of Total	—	—	45.4	27.3	27.3	—	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
1	5	—	2	2	1
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
—	—	—	—	—	11

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	7	3	10
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	7	3	10

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
265	5.2	84	31.7	91	9	270	1

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	—	—	—
Day Centres	3	31	57
Out-patient clinics	7	161*	879

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
5	24	3	29	1	28

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
7	5	58	14	2

COST

The cost of the West Cork Mental Health Service was 3.2 million in 2002

GENERAL COMMENTS

Apart from the opening of the high-support residence, Ard na Realt and the St. David's Resource Centre in Clonakilty, there had been no further developments in this service since our last visit in 2002.

Bantry Psychiatric Unit had been given the status of a District Mental Hospital in 2002. This was so that PUM patients could be received in the unit and would not, therefore, be taken by Garda escort to Cork. There were accommodation and observation difficulties in dealing with some of these patients because of the layout of the unit. To overcome this problem it was recommended that a design team should advance the planning of a high-observation area for patients requiring acute care. This would also end the practice of transferring admitted patients, and deviating others referred, although not of PUM status to Cork without admitting them.

The Inspectorate was deeply concerned at the practice where patients referred for assessment were seen, for the most part, by junior doctors and decisions then made as to whether they should be admitted to the Bantry unit or sent to Cork, which in effect meant the intensive care unit at Carraig Mór, often under Garda escort. Apart from the violation of the principle of the least restrictive alternative this practice brings into question the purpose, and indeed the usefulness of having an in-patient psychiatric unit in West Cork, at all. The Inspectorate had been advised that some patients whose admission applications had been made out to the unit at Bantry had been sent on to Cork with the designated hospital unchanged, in the expectation that they would be received in the Cork hospital (Carraig Mór) — which would not meet the requirements of the Mental Treatment Act, 1945.

There were no specialised services for later-life or rehabilitation available to the West Cork services. Once again, it was apparent that the provision of a comprehensive psychiatric service with a full range of sub-specialities available was not feasible to a self-contained catchment population of 50,000.

In the light of these considerations, and the evident cost-inefficiency of running an inpatient unit for such a population, a more satisfactory manner of providing a service to West Cork would be to place resources into establishing an acute and assertive outreach care delivery model, providing sub-specialty access, particularly for the elderly and for rehabilitation, to the catchment area. This would drastically reduce the need for acute hospital accommodation and the future of the Bantry Unit would become problematic.

Under these arrangements, dependence on the Bantry unit would diminish with the release of staff to provide the community services alluded to. This was all the more relevant given the existing nursing shortage.

One male patient was admitted under a PUM certificate to Bantry General Hospital during 2002. Twenty-three patients were admitted involuntarily under temporary certificates to the West Cork Mental Health Service in 2002. Sixteen of those patients were regraded to voluntary status during the course of their hospitalisation. Ten patients were regraded from voluntary status to involuntary status following admission. Six patients were admitted to the psychiatric unit following liaison consultation in the local General Hospital and a further 72 were referred following consultation at the psychiatric out-patient department. Six patients were transferred from the unit at Bantry General Hospital to the Carraig Mór unit in Cork. Nine patients took their own discharge from the services during 2002 against medical advice and appropriate procedures were in place to follow-up these patients if deemed clinically appropriate.

ECT therapy was not prescribed for any patients in this service during 2002. There were no research projects governed by the Clinical Trials Act, 1987 — 1990 undertaken in the service. Six patients were placed on special nursing supervision, one- nurse supervising one- patient continuously and there were 150 spans of special nursing supervision during 2002.

Seclusion was not used in this service. However, as stated in the Inspector's report of 2001 it was felt that this service should have access to a dedicated safe room for emergency purposes only in the interest of safety and welfare of patients and staff.

There were 4 requests made to the local complaints manager under the Freedom of Information Act, 1997 and all appear to have been dealt with satisfactorily. Information relating to the number of recorded complaints made was not available at the time of inspection. The Inspectorate welcomed the introduction by this service of a standardised form to record that information had been given to patients about their legal rights under the Mental Treatment Act, 1945 and amending legislation. This form was incorporated into the nursing documentation and was completed satisfactorily in all notes examined.

Accidents, injuries and assaults in the West Cork Mental Health Service were classified according to seriousness of outcome. There were 80 recorded accidents to patients, 24 resulted in minor scratches and 3 were deemed serious. There were 9 recorded assaults on patients by other patients, 5 resulting in minor injury and none deemed serious. The two recorded assaults on staff were not deemed serious.

Management of the service were reviewing and updating guidelines, policies and procedures in accordance with service needs and current good practice. These should have a multi-disciplinary focus where appropriate, be headed with the hospital title, be individually numbered, note the author or point of referral, record the date of ratification and by whom; where possible be research based, referenced and relevant authorities noted, have a review by date, audit by date and detail responsibility for these. A computerised index of all policy documentation should be kept which records date of ratification, implementation and review. Revised and superceded policies should be removed from operation.

An environmental health and safety audit was conducted at the Bantry Unit in April 2003. The fire and safety committee met approximately 4 times per year and appropriate records were kept. The checking system to ensure equipment operated efficiently in emergency appeared satisfactory. All inspections were recorded, dated and signed. There was a formal induction process for new staff and training was provided on cardio-pulmonary resuscitation, the management of aggression and violence and safe lifting techniques. The existing day area presently constituted a combined smoking and non-smoking area. In the light of the draft regulations on smoking which would prohibit the smoking of tobacco products in the workplace, there was need to introduce guidelines for implementing the policy for a smoke-free workplace in Bantry Hospital.

Each service unit within the West Cork Mental Health Service had a written statement of purpose and function outlining the key policies that were in place.

The location and lay-out of the community residences in the West Cork service was suitable for its stated purpose and accessible, safe and well maintained. Residences met patients' individual, dual and collective needs in a comfortable and homely way. Grounds surrounding community residences were kept tidy, safe and attractive and accessible to service users. Some re-decoration was required at the St. Anne's residence in Skibbereen and appropriate day service should be considered for this area.

The quality and choice of food for patients in the Bantry Unit was satisfactory with a set menu. The physical environment of the dining areas and the standard of hygiene and food preparation areas all appeared satisfactory. The dining room while satisfactory could appear overcrowded when the unit was operating at full capacity.

A number of clinical files, randomly selected, were examined as part of this inspection. A new filing system had been introduced since the last inspection. Written instructions on filing of documentation within the medical record were available. Each newly-admitted patient had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and clear immediate management plan appropriately recorded in the notes examined. The Inspectorate noted that the files had a back pocket for the storage of the medication recording cardex only. It was also noted that this back pocket contained discharge letters and other pertinent clinical information. Risks associated with this form of haphazard filing included loss of misfiled clinical information or delays in accessing pertinent information.

The policy for ordering, prescribing, storing and administration of medicines was under review. The standard of prescription writing varied. A small number of prescriptions appeared difficult to read. All prescriptions should be signed and individually dated and include the full signature of the prescriber. It was noted that the discontinuation column was not always completed for discontinued drugs. In a number of cards it was noted that discontinued prescriptions were greater in number than current prescriptions and there was a moderate risk of drug error. The nursing component of the clinical file comprised a dedicated booklet with patient assessment and care plan. The biographical data sheet for each admission was completed satisfactorily. Time of entry should also be recorded using the 24-hour clock.

The management team of this service met on a monthly basis and minutes were kept. The service should produce a local three-year strategic development plan, setting out service objectives and how they are to be met. In tandem with this, patients' views in relation to health service provision should be sought.

Three patients were interviewed to access their opinion of the services provided. All were satisfied with the courtesy and helpfulness of the staff. All patients knew their consultant psychiatrist. However, two patients said they saw a junior doctor frequently, but seldom saw their consultant. All patients reported that they were not aware of their rights under the Mental Treatment Act, 1945, although one patient had received some information about her medical condition and proposed treatment from the nurses. This patient would have preferred a more in-depth explanation. Patients were generally satisfied with all aspects of privacy and dignity relating to their care and with the cleanliness of the facilities. One patient felt that privacy needed to be improved in the toilet areas. All patients were satisfied with the quality and quantity of food provided. When asked how they would like to see the services improved all said they would like to see their consultant psychiatrist on a more frequent basis. One found the sleeping arrangements noisy at times and would prefer a single room. All patients would appreciate getting written information on their medications.

RECOMMENDATION

It is recommended that:

As a matter of urgency, senior health board management review in a fundamental manner the current functioning and utility of this service, given its current serious inadequacies. In particular, the proposed review should address the principles and mechanisms of delivering a service that is comprehensive, sub-specialised, multidisciplinary, community-provided and cost-efficient with the resulting reduced need for in-patient care at Bantry.

CHAPTER NINE

Western Health Board

EAST GALWAY MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 23 APRIL AND 28 OCTOBER, 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 98,928 was divided into four sectors as follows:

Sector	Population
Gort/Portumna (Sector A)	22,027
Loughrea (Sector B)	24,480
Ballinalsoe (Sector C)	24,734
Tuam (Sector BC)	27,687

IN-PATIENT CARE

In-patient care was provided at St. Brigid's Hospital, Ballinasloe, which had 288 beds in six male, three female and six integrated wards. There were specialist services for rehabilitation and a network of community-based facilities.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	24	11	8	5	49	18.1
3-12 Months	—	—	6	7	4	4	21	7.8
1-5 Years	—	—	3	19	6	7	35	13.0
> 5 Years	—	—	8	41	55	61	165	61.1
All Lengths of Stay	—	1	41	78	73	77	270	100
% of Total	—	0.4	15.2	28.9	27.0	28.5	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
15	122	3	25	18	11
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
9	20	—	45	2	270

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	127	82	209
Temporary	15	7	22
P.U.M.	1	8	9
Ward of Court*	3	2	5
Total	143	97	240

*included in voluntary/temporary figures

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
741	7.5	246	33.2	81.2	18.8	734	16

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	3	Not Applicable	785
Day Centres	6	122	214
Out-patient clinics	12	472*	1,505

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
33	140	6	31	10	94

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
16	39.5	315	206.9	15

COST

The cost of the East Galway Mental Health Service was €32 million in 2002.

GENERAL COMMENTS

Following the 2002 inspection, the Inspectorate issued a special report to the Minister for Health and Children on conditions prevailing in St. Brigid's Hospital, Ballinasloe and on the impediments to changing and improving them. The unacceptable conditions in the hospital and the consequences for patient care were pointed out in this report. The negative effect of the influence of the staff representative bodies on moving forward towards

improvement was also stressed. As a consequence, the Western Health Board established a Group, representative of all concerned interests, with a neutral chairman skilled in industrial and partnership issues, to reshape the East Galway Mental Health Services. This initiative was followed by the appointment of a project manager. The Inspectorate understood that this group had been meeting on a regular basis and had established sub-committees to consider specific areas of service development. What was clear to the Inspectorate, however, was that progress had been slow and that the Group would continue its deliberations for some time yet. However, there was some optimism in the fact that all parties were working together.

Much of what led to the Inspectorate's special report in 2002 was still in evidence on this visit. Conditions in most wards of the Old Building remained unchanged and staff should not be expected to work, nor patients be cared for, in them. However, the Inspectorate acknowledged the closure of ward three and the moving out to nursing homes of patients from this and other wards; a process that was to be continued. There was also a plan for the entire hospital, leading ultimately to the closure and sale of the old building. This, in the Inspectorate's view represented significant progress.

Wards 1 and 5 were to be amalgamated as a temporary measure pending patients' transfer to other locations, community residential places in some cases, and to an intensive care unit for the more disturbed patients. The Inspectorate would suggest that the St. Joseph's unit would make an ideal intensive care unit for the Western and neighbouring health boards. Elderly patients in the other Old Building wards would move to nursing homes or to the New Building which should take on a specialised function for later-life psychiatry, as part of the generic services for the elderly in East Galway. Indeed, some had already gone and others were due to move shortly to nursing homes. It should be borne in mind, that over 60% of St. Brigid's residents were over 65 years of age and that over 30% were over 75 years. There were more than 60 intellectually disabled patients in the hospital, some in ward 3, others inappropriately accommodated with functionally psychotic patients in other wards. The plan was to place these patients in community settings and apparently the capital resources were available to effect this transfer.

In the new building, plans were in place to rationalise the accommodation, for instance to move male patients from ward 21 to ward 19, thereby improving both wards. The Inspectorate understood that an application had been made for the appointment of a consultant psychiatrist for later life. When this happened and a team was established for this subspecialty, ward 17 should become an active acute assessment unit with the placement of the current long-stay patients in continuing care. This acute assessment function should be viewed as a stop-gap measure, pending the acquisition of an acute unit.

The Inspectorate were disappointed to learn that the provision of an acute admission unit at Portiuncula Hospital, which was being promoted some years ago, ironically before the Western Health Board had acquired the hospital, was no longer on the agenda. This was disappointing given the unsatisfactory and unsuitable nature of the present admission facilities in St. Brigid's Hospital, despite recent upgrading. The provision of an acute

admission unit at Portiuncula would help to stem the large number of inappropriate admissions and help in the establishment of an admission policy which did not seem to exist. The service had an unacceptably high admission rate which was not helped by the persistence of the West Galway overflow still running at almost 100 per year. The only satisfactory way to deal with this long running problem would be to convey district mental hospital status on the psychiatric unit in University College Hospital, Galway.

A much-needed specialised rehabilitation service had been established and, as well as medical and nursing personnel, an occupational therapist had been appointed with a social worker and psychologist to follow.

There were 315 nurses and 87 ward attendants employed in direct patient care; with the vast majority of those working in St. Brigid's Hospital itself. This was generous staffing compared to other catchment areas of similar size and population. One of the challenges facing the Reshaping Group would be the moving of nursing staff from the overstaffed hospital to more professionally skilled activities that are community based. The resistances to this move would be strong, as exemplified by two current difficulties. The first concerned the resistance from assistant directors of nursing to relinquishing their current unnecessary night duty work. The second concerned the attempt by the service to close the redundant residential provision for the treatment of alcohol abuse in the former nurses' home, despite no one having been resident there for over six months in the face of mounting misplaced community pressure to keep it open. The role and function of the assistant directors of nursing, many of whom rotated on night duty, should be reviewed with a view to establishing greater continuity at senior nursing level within the developing sectors of this catchment area.

While the Inspectorate recognised that a considerable number of patients in St. Brigid's Hospital were elderly, many remained unoccupied on wards all day. Therapy programmes should be introduced at areas adjacent to those wards to enable patients engage in social and recreational activities appropriate to their needs.

Accommodation in Mountbellew and Tuam community residences was of good quality, comfortable and well designed with furnishings and décor to meet the needs of residents. Residents in each house had access to a telephone and knew who to contact in the case of emergencies. There was a need for refurbishment and redecoration of the Toghermore house, including the toilet facilities. There was no easy access to public transport or community facilities, although all of the residents attended the nearby workshop. As most of the residents were of advancing years, facilities appropriate to their needs were required. A decision would have to be made whether this facility functions as a high-support community residence or as a nursing home for older patients. A service users' guide, including the terms and conditions of residency and the scale of weekly charges should be provided for residents.

The Inspectorate welcomed the improvements at the Toghermore training centre. The enthusiasm of the staff and trainees and the engagement in community activity ensured that the centre actively promoted a positive image of people with mental health difficulties.

All of this was done in a way that safeguarded persons' rights to privacy and confidentiality. The Inspectorate felt that the Headford day centre was under-utilised. While the premises needed substantial upgrading, there was development potential for a combined day centre and supervised community residence.

There were 80 temporary admissions and 59 PUM admissions to St. Brigid's Hospital in 2002: nine temporary admission orders were extended. Eleven patients admitted voluntarily were re-graded to temporary and 38 patients admitted involuntarily were re-graded to voluntary status during the period of hospitalisation. One person admitted to St. Brigid's Hospital was less than sixteen years of age. In 2002, 13 patients became new long stay, i.e., continuously hospitalised for longer than one year and less than five years; two of those patients were aged sixty-five years and over. There were 734 discharges from St. Brigid's Hospital in 2002; 11 patients took their own discharge against medical advice, 21 patients were discharged to other psychiatric services, 14 of those were to the psychiatric unit in Galway. There were 16 deaths in St. Brigid's Hospital in 2002.

There were 23 recorded accidents to patients and 32 recorded accidents to staff during 2002; 20 accidents resulted in minor injury and 17 were deemed serious. Of the four recorded assaults on patients by other patients and the 16 recorded assaults on staff none were deemed to be serious.

In 2002, 56 patients were prescribed ECT; six of the patients were from the West Galway catchment area and a further two were non-catchment area patients. There was a dedicated ECT suite with a named consultant responsible for the ECT clinic at the admission unit complex. The physical examination prior to ECT was appropriately recorded in the notes and there was an assessment of clinical outcome recorded post each ECT treatment. The Inspectorate was pleased to note that in all records examined, practitioners recorded that they were satisfied that the patient fully understood the nature of the procedure and all material risks and benefits. The pre- and post-ECT nursing checklists were completed satisfactorily.

There were 152 episodes of seclusion, involving five patients at St. Brigid's Hospital in 2002. A seclusion register was maintained and 15-minute nursing observations as required under the Mental Treatment Act, 1945 appropriately recorded. The policy and procedure relating to seclusion had been updated since the previous inspection. The safe rooms at ward 5 which had been upgraded in recent years were of a satisfactory standard; the rooms at ward 1 were in a deplorable condition as mentioned in previous reports. There was evidence of smoking in the seclusion rooms with burn marks on the floor and the walls. These rooms were not safe with torn lino and dangerous fittings. Nursing and medical documentation in relation to each seclusion episode examined was cross referenced to the special seclusion register. A multidisciplinary review should be completed and documented for each seclusion episode.

A number of clinical files were examined and, as reported in previous years, the overall standard was variable. Written instructions on filing of documentation within the medical record were required. The patient's name was not always recorded on each continuation

page even though there was provision made for this. Time of entry should be recorded on all inputs which should contain the signature in full of the staff member making the entry. While the date of record was stated, time of assessment should be recorded using the 24-hour clock.

The nursing records examined across the hospital service were also of a variable standard. In all of the long-stay wards nurse care planning had fallen into disuse and basic nursing notes were recorded, with infrequent entries in some areas. There was also a major difficulty with loose pages of continuation nursing notes. A new recording and filing system should be given serious consideration. Where nursing care plans were used — in the admission units — the ‘Roper’ model of nursing was applied. Records examined identified problems that had arisen and actions taken by staff to rectify them. The up-to-date biographical data sheet for each admission was recorded satisfactorily. There was provision for recording allergies and drug sensitivities which was not always recorded.

The complaints or dissatisfaction procedure available to patients was satisfactory. There was a comprehensive information booklet available in the admission units but not in the other wards of St. Brigid’s Hospital. It was not clear whether patients were aware of its existence or informed how to use the complaints process. While information on patients’ rights was contained in the information leaflet it was not clear if this was brought to their attention. There were no formal complaints made to the local complaints manager in 2002. In relation to one patient in ward 10 whose temporary period was extended, the Inspectorate noted that the consultant recorded that the patient’s rights were fully explained to him prior to the decision to extend the period of detention. This was very satisfactory.

There were 16 requests made under the Freedom of Information Act, 1997 in 2002. There were no research projects governed by the Clinical Trials Act, 1987-1990 undertaken in the East Galway mental health service.

In 2002, there were 610 episodes of one-nurse to one-patient special nursing supervision involving 46 patients. There were 151 consultations at the nearby Portiuncula Hospital, provided by the consultant psychiatrists of the East Galway service. Outcome of these consultations relating to admission or referral to other service components was not available. While it was appreciated that some of the liaison consultations were for patients outside the East Galway catchment area, records of the outcome of all consultations should be kept and audited on a yearly basis.

The designated smoking areas within the admission unit complex appeared to be working well. Most of the wards in the long-stay block had no, or inadequate designated smoking facilities, and, in some places, it was noted that the smoking policy was not rigidly enforced.

A number of policies, procedures and guidelines had been reviewed and updated by a policy review committee and introduced by the local management committee. There was also an index of all policies. There was a medicinal products policy and procedure at all locations for staff information and reference. The standard of prescription writing was

variable. Some prescriptions were in block writing and very easy to read. However, it was noted that a small number of scripted prescriptions were difficult to read. Whilst provision for recording the date and signature for each prescribed medicinal product and the date and signature for each product discontinued the standard again was quite variable; in some wards it was very satisfactory and in others it was noted that the discontinuation column had no date and no signature. In a number of the long-stay wards there was an increased risk of drug administration error because the number of discontinued drugs were greater in number than current prescriptions. All of these cards should be rewritten.

Three patients, two male and one female, in the admission unit were interviewed to assess their opinions of the services provided; all were of voluntary status and one was on his first admission to the unit. All patients were satisfied with the courtesy and helpfulness of staff, were introduced to the professional team responsible for their care, and knew the name of their consultant psychiatrist. They were pleased with the frequency of consultation with their consultant psychiatrists and the ease of accessibility to them. While the 'primary nurse system' was in operation in the unit one patient hadn't recognised its significance. However, he was aware that he had a nursing care plan. There were various occupational therapies available. One patient particularly liked the art classes and relaxation therapy exercises. However, as these therapies were provided in an upstairs ward one patient was not keen to participate in them. Two patients were not aware of their rights under the mental health legislation or of any complaints procedure. All patients were satisfied with the cleanliness and hygiene of the unit. One patient was awaiting more in-depth consultation into his psychological problems. He was anxious to learn all about his illness and mechanisms to counteract such developments. None of the patients interviewed offered suggestions as to how the service might be improved.

RECOMMENDATIONS

It is recommended that:

1. The Reshaping Group expedite its deliberations.
2. The plan for the rationalisation of St. Brigid's Hospital, as outlined to the Inspectorate and set out in the general comments above proceed without delay.
3. Planning be immediately reactivated for the provision of an acute admission unit in Portiuncula Hospital.
4. The wards in the new building be de-designated.
5. The Headford premises be utilised to its full potential.

WEST GALWAY MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 23 JULY AND 26 AUGUST 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 100,000 was divided into four sectors as follows:

Sector	Population
Oughterard	9,500 (+15,625)*
Clifden	8,600 (+15,625)*
Carraroe	10,500 (+15,625)*
Oranmore	8,900 (+15,625)*

*Represents a quarter of Galway City population

IN-PATIENT CARE

In-patient care was provided at the 43-bed acute psychiatric unit, University College Hospital, Galway (UCHG), which had one male and one female unit and integrated dining and activities area. There was also an integrated rehabilitation unit (9A) which had 30 beds. Community services were provided on a sector basis.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	21	15	8	2	1	28	41.8
3-12 Months	—	—	4	3	3	—	10	14.9
1-5 Years	—	—	4	7	3	—	14	20.9
> 5 Years	—	—	—	11	4	—	15	22.4
All Lengths of Stay	—	2	23	29	12	1	67	100
% of Total	—	3.0	34.3	43.3	17.9	1.5	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
1	38	1	13	4	1
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
—	4	2	3	—	67

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	16	16	32
Temporary	7	3	10
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	23	19	42

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
648	6.5	176	27.2	88.1	11.9	644	—

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	20 per day	181
Day Centres	4	100	136
Out-patient clinics	4	420*	1,065

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
5	24	5	28	1	7

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
13	14.5	89.5	16	15.5

COST

The cost of the West Galway Mental Health Service was €9.9million in 2002.

GENERAL COMMENTS

There had been considerable movement in this service since the last visit of inspection. In particular, a planning approach had evolved with clearly defined targets and objectives. Plans for strengthening the inpatient component and for extending community services, with an overall commitment to improving service delivery to the catchment area, were evolving. An extension of the existing specialist services, which up to now had been limited to the provision of a specialised service for the elderly, was now being contemplated. The other identified specialist requirements were a consultant for liaison work, either on a special interest or a full-time basis to service the general hospital, and a defined rehabilitation and day hospital consultant-led service. The Inspectorate had some reservations about this combination of responsibilities and services. It was the Inspectorate's view that a full-time consultant post in rehabilitation psychiatry should be created to head up the newly-created rehabilitation team. It was the Inspectorate's belief that a consultant exclusively for the day hospital would have the effect of isolating the day hospital activity from the sector teams and lead inevitably to discontinuity of care. There should be a day

hospital in each sector, run by the consultant-led team of that sector. Even if this were not attainable the day hospital should have input from all consultants and their teams.

Another requirement, in this and in other services in the Western Health Board, was that of a psychiatrist specialising in the intellectual disability. The absence of such a post caused considerable strain and deficiencies in all four Western Health Board services. The child and adolescent consultant post in West Galway was vacant and, while a locum was in place, no attempts had been made to fill this on a permanent basis; the service providers felt this was an urgent requirement.

Deficiencies in the community services still existed but attempts were being made to remedy matters. The day hospital premises attached to the in-patient unit at University College Hospital was to be moved to a new premises in Ballybane in Galway City. This would free-up the existing premises, which would then be used as an out-patient base and for the supervision of Clozaril patients. Apparently, the service had been unable to acquire out-patient premises in the out-patient department in University College Hospital, with the result that out-patients came to the unit creating security problems. The proposed movement of these patients to the day hospital was seen as a considerable improvement. However, the Inspectorate would prefer to see out-patient activity based in generic health centres. If this were to come about then the day hospital premises could be used for other purposes, such as, accommodating the acute assessment unit for older people or the close observation facility for the unit. In addition to the Ballybane day hospital more was required by way of day hospital premises and activity, preferably in every sector. In this regard, it was hoped to extend the current day activity at Clifden so that it would take on more of a day hospital function with a greater consultant and other medical presence and a similar ambition existed at Carraroe for that sector. Attempts to establish a day centre in Acorn House in Galway City had fallen through because of community objections. The Board still owned the premises and was striving to adapt it for residential use.

There was a need for further community-based residential accommodation. The majority of patients in Unit 9A, Merlin Park, were ready for community residential placement if 24-hour nursing supervised hostels were available. It was envisaged that Acorn House would be available in 2004 to take at least five residents. There had been some improvement in Unit 9A since the last visit of inspection and further plans had been drawn up to improve the existing accommodation. Nevertheless, the premises did require upgrading, re-painting and improved furnishings. It was functioning as a high-support residence and because of that should, in the Inspectorate's view be de-designated. Its function as an overflow facility for acute admissions from the acute psychiatric unit still continued, although, on a diminished basis with only 53 bed nights occupied during 2002. Nevertheless, as the Inspectorate reported last year this was fundamentally unsound practice both from an ethical and safety point of view and should be discontinued. The Inspectorate was at a loss to understand why 43 acute beds should not be adequate to serve the community and whether the current high admission rates needed further scrutiny. The Inspectorate was told that all admissions to the acute unit in UCHG were consultant determined. The Unit was open but special nursing was a prominent feature of the day-to-day routine.

Plans had been drawn up and funds apparently guaranteed for a six-bedded high-observation area to supplement the existing 43 beds. However, no progress had been made on this front. In addition, no acute assessment beds were available, in a separate area, for the later-life psychiatric services to which a consultant would shortly be appointed.

There had been some improvements to the Unit since the last visit of inspection. The external windows and the entrance had been improved. Internally, leaks from doors and roof windows had been eliminated. In addition, the shower and bathing arrangements had been much improved. The dining arrangements had been greatly improved, in that the former large area which catered both for day purposes and in which patients both smoked and dined had now been sub-divided, with the dining area now being entirely self contained and some of the remaining space being used for smoking purposes. However, in the garden courtyard a 'gazebo' had been created for smokers with the ultimate ambition that this would be used exclusively for smoking purposes, with the existing smoking area being converted to other uses. The garden courtyard itself was the subject of revitalisation and improvement with planting, seating, etc. The former dining space had been converted into a self-contained gymnasium with expensive equipment provided by the Health Promotion Department, private funding and the pharmaceutical industry.

The Inspectorate was told that approximately 30 patients had been transferred to St. Brigid's Hospital, during 2002, a greatly reduced number which, at one time, was running at about 150. However, since the Unit was not a district mental hospital, PUM patients were conveyed directly from the catchment area by the Gardaí to St. Brigid's Hospital. The Inspectorate would like to see the Unit become a district mental hospital and deal with its entire catchment area without recourse to St. Brigid's Hospital. The impression seemed to be that there would be no difficulty in doing this when, and if, the acute observation unit came into being. The Inspectorate wondered whether it was necessary to wait for this to happen.

There were four occupational therapists, three social workers and two psychologists in the services and there was a commitment to increasing their number to provide full multi-disciplinary input in all sectors. Nursing numbers, at 89.5, were relatively limited by comparison with, for example, the neighbouring service of Co. Roscommon with 129 for approximately half the West Galway catchment population. It was pointed out to the Inspectorate that the Galway service had only somewhat lower funding than Roscommon. This was felt to be hindering progress, as the service would very much like to set-up outreach home-care programmes in all sectors.

There were 77 non-voluntary admission orders to the West Galway services in 2002, with no extensions of temporary admission forms. Twenty-eight voluntary patients were re-graded to temporary status whilst hospitalised and seven patients admitted as involuntary temporary patients were re-graded to voluntary status. There were 14 complaints and nine Freedom of Information requests made to the local complaints appeals manager in 2002; all appeared to have been dealt with satisfactorily.

In 2002, 29 patients were prescribed ECT at University College Hospital, Galway. The facilities for ECT comprise waiting, treatment and recovery areas and were of a high standard. However, the extensive ECT suite was used less with the general diminution of this treatment. The Inspectorate wondered whether that space might be utilised for other purposes, such as the acute assessment of the elderly or for close observation. The Inspectorate was assured that the planning group was looking at this.

There were 762 episodes of special nursing supervision involving 35 patients during 2002. Thirty-five accidents to patients and three accidents to staff were recorded during 2002; eleven resulted in minor injury. Also, three assaults on patients and 11 assaults on staff were recorded; none were deemed serious.

The standard of prescription writing and drug recording in the acute unit at University College Hospital, Galway was satisfactory. A new prescription writing policy had been introduced since our last visit. All prescriptions were signed and dated individually as was the discontinuation column. While there was provision within the prescription cards for recording known drug allergies/sensitivities, this was not always completed in the cards examined.

At the time of inspection, all policies, procedures, protocols and guidelines were under review and a set of 25 updated policies had been approved with an effective implementation date of the 16/6/2003. It was noted that there were two policy manuals available, nursing guidelines dated 1991 which contained information on disciplinary and grievous procedures, sick leave procedures etc. As these were essentially staffing matters they should be in a separate manual from the policies, procedures and guidelines relating to the care, safety and welfare of patients. The comprehensive policy for patients absent without official leave, which was ratified in June 2003 should include information on organising a local search and include a map of the hospital grounds.

The admission notes on individual clinical files examined were satisfactory. Written instructions on filing of documentation within the clinical file were available. Each newly-admitted patient had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and clear immediate plan appropriately recorded in the notes examined. While the date of entry was recorded it was recommended that the time of entry also be recorded and it was useful in determining delays in assessment or treatment. There was a considerable collection of loose clinical material in open pockets of many of the files examined. There were certain risks associated with unsecured contents e.g. misfiled information and delays in accessing pertinent information when required. A standard information form was given to each patient on the day of discharge which contained prescribed medication, name of the hospital and phone number. A discharge summary issued to the referring general practitioner within a reasonable time.

The 'Roper' model of nursing care was used at the acute psychiatric unit. A number of nursing records were examined. The up-to-date biographical data sheet for each admission was completed satisfactorily and there was a statement in the nursing assessment giving a physical description of the patient. Time of entry should be recorded using the 24 hour

clock. The cardex system in use was bulky and there was considerable collection of loose pages of nursing notes which were at times difficult to follow. It was suggested that the nursing records be audited to identify areas for improvement and staff development. The primary nurse or team allocation nurse name should be entered in the nursing records.

The service ran a training programme for medical students and for postgraduate medical training. The professorial post had been restructured towards a fifty per cent clinical/fifty per cent teaching responsibility and a new post of senior lecturer had been created. There was a commitment to improving teaching patient evaluation, assessment and all documentation procedures. This was welcomed by the Inspectorate, particularly as current case-note structure was less than ideal. This was currently under review and a new, integrated, comprehensive follow-through case note was being designed.

The Unit and its activity had been the subject of both a self accreditation and an external mental health review. Also, the Inspectorate was given the final report of the academic quality assurance programme. A patient information booklet had been produced and given to patients on admission.

Three patients, two females and one male, randomly selected, were interviewed in order to determine their level of satisfaction with the care provided. All were voluntary and had previous hospital admissions. All were satisfied with the courtesy and helpfulness of staff, were introduced to the professional team responsible for their care, and knew the name of their consultant psychiatrists. They were particularly pleased with the frequency of consultation with their consultant psychiatrist and the ease of accessibility to them. All were pleased with having the 'Primary Nurse System' in operation and they felt fully involved. However, they were unsure whether they had individual care plans. One patient was particularly pleased with the service provided by the social worker. They were aware of their rights' under the Mental Treatment Act, 1945 and had received a hospital booklet containing relevant information regarding their illnesses, medications and their side effects; this they found very useful. When asked about the complaint procedure two agreed that they had nothing to complain about and the third felt the activity area needed revamping. When asked for their suggestions for the improvement of the services provided, one said he would like more stimulating recreational and social activities.

RECOMMENDATIONS

It is recommended that:

1. The service press ahead with the plans for improved and extended day hospital and residential accommodation as outlined.
2. A close observation area be set up within the acute unit, leading to the designation of the unit as a district mental hospital, so as to eliminate the transfer or direct admission of catchment area patients to St. Brigid's Hospital, Ballinasloe.
3. Unit 9A, Merlin Park, be de-designated and the practice of transferring acute patients from the acute unit in UCHG to this Unit therefore cease.

4. Funding be made available to develop the long awaited high support hostel in Carraroe.

MAYO MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 11 & 12 NOVEMBER 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 117,000 was divided into five sectors as follows:

Sector	Population
Castlebar	21,000
Ballina	26,000
Westport	26,000
Claremorris/Swinford/Kiltimagh	23,000
Achill/Belmullet	21,000

The Mayo Mental Health Service provided general adult psychiatric services and specialised care for psychiatry of later life through a network of community-based services and inpatient care at St. Mary's Hospital, Castlebar, which had 116 beds in three male, two female and two integrated units.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	12	9	—	—	21	18.1
3-12 Months	—	—	3	6	—	—	9	7.7
1-5 Years	—	—	10	5	2	—	17	14.7
> 5 Years	—	—	2	24	20	23	69	59.5
All Lengths of Stay	—	—	27	44	22	23	116	100
% of Total	—	—	23.3	37.9	19.0	19.8	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
2	56	9	11	12	2
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
2	7	—	15	—	116

Status of In-Patients on date of Inspection 2003 (includes Patients in St. Mary's Hospital and St. Teresa's Unit)

Status	Male	Female	Total
Voluntary	68	44	112
Temporary	7	5	12
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	75	49	124

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
600	5.1	174	29	83.2	16.8	612	12

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	2	45	175
Day Centres	7	137	392
Out-patient clinics	15	323*	1,048

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
10	42	8	62	2	18

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
12	29.49	248.5	105.67	12.91

COST

The cost of the Mayo Mental Health Service was €19.8m in 2002.

GENERAL COMMENTS

Two matters, both negative, stood out in the mind of the Inspectorate after visiting the Mayo services. The first was the disappointment that the new acute unit in Mayo General Hospital had not opened, despite being available since the previous visit in 2002¹. The second was the intolerable conditions prevailing in the intensive care unit in St. Mary's

¹ This unit subsequently opened in December 2003.

Hospital. A further frustration was that the new high-support unit Ashling, in Castlebar had not opened. Once again, in matters of opening new facilities patient welfare had become subservient to staff vested interest.

However, there was some good news. Nursing unions had accepted offers made to them and the way was now clear to open the General Hospital Unit; this was anticipated in a matter of weeks. Nevertheless, the Inspectorate had some reservations that the necessary policies and procedures to ensure management of the unit from the beginning had not been worked out satisfactorily. For example, the admission policy in relation to where persons presented for assessment, which in the Inspectorate's opinion should in all cases be through the Accident and Emergency Department, had not been finalised. It appeared that there had been a recent visit of the British Royal College of Psychiatrists for purposes of accreditation of the service for post-graduate medical training purposes and this party had objected to the location of the interviewing room and also apparently insisted, contrary to our fire and safety regulations, that the door of this room should open outwards rather than inwards. The Inspectorate stressed that it was vital that all the necessary policies and the procedures for their implementation should be in place before opening the unit, even, if in the light of experience some modification became necessary later.

In relation to the new, high-support residence, Ashling, and its accompanying workshop, also ready for occupation for more than a year, it was shameful that the patients to transfer there, most of them in the intensive care unit should have had to remain in those deplorable conditions. However, the Inspectorate was informed that this would shortly open. Rehabilitation of these patients should begin as soon as they arrive in Ashling and this should only be a stepping stone to further staged rehabilitation in the rehabilitation unit, when that opened.

There was a plan in place which would lead in a short time to the closure of St. Mary's Hospital. This involved the moving of acute in-patient facilities from St. Theresa's Unit to the General Hospital, the establishment of a rehabilitation unit in the former St. Theresa's Unit following its closure and refurbishment, which it was anticipated would take a year. This made more urgent than ever the establishment of a multi-disciplinary rehabilitation team. Some of the upgraded St. Theresa's might function as a continuing care unit for the elderly who encompassed most of the long-stay in St. Mary's Hospital. It was vital to ensure that the new St. Theresa's unit be an active rehabilitation unit; the frequent use of the term "continuing care" when referring to it was not well received by the Inspectorate.

A plan of assessment of the suitability for transfer to nursing homes of the older St. Mary's patients had been completed by the staff. During this visit, staff from the largest of these nursing homes was visiting to meet some of those patients who would shortly transfer to them. Matters were not so advanced as far as the small number of intellectually disabled patients was concerned and no satisfactory arrangement appeared to have been reached with Aras Attracta in Swinford on their acceptance of these persons, particularly one man in ward 7 for whom the highly undesirable alternative was moving to the Ashling high-support unit. These difficulties pointed to the need for a consultant-led, specialised service for the psychiatry of intellectual disability.

The consultant for later-life psychiatry had taken up post and was recruiting a multi-disciplinary team and establishing the operating principles and plans for this service which now had obtained extensive accommodation in the former St. Anne's. The task of establishing headquarters for this service on the premises was already under way. Other plans included the conversion of the existing residential accommodation towards catering for the more disturbed patients and resourcing continuing care for behaviourally less compromised patients elsewhere, in nursing homes for example. Temporary day hospital accommodation would be provided in this building but the ultimate aspiration was to acquire premises in the general hospital. Good working relations were being established with the generic services for the elderly, particularly with the community nursing units at the district hospitals at Castlebar, Swinford and Ballina.

There had been some developments in community provision. The community clinic in front of the general hospital would be adapted to serve as the sector headquarters for the Castlebar sector and should also provide an acute day hospital. The new premises at Claremorris had the potential to function as an acute day hospital if some of the space allocated to staff was re-oriented towards patient usage. In common with most services, there was little by way of acute day hospital activity in operation in the sectors and it was unclear whether operationally the concept was fully comprehended. In the Claremorris sector, there would shortly begin a home-based, outreach programme of delivery, something to be welcomed and replicated in other sectors.

There were 600 admissions to St. Mary's Hospital in 2002, 97 of which were on temporary admission orders and a further four on PUM certificates. During 2002, 31 patients hospitalised on temporary admission orders had their involuntary admission orders rescinded and were admitted as voluntary patients during the course of their hospitalisation; 26 of the voluntary patients had their legal status re-graded to temporary patient and 55 patients were lodged overnight at the St. Theresa's Unit but not formally admitted to the hospital. Six patients hospitalised on temporary admission orders had their involuntary admission orders extended during 2002. There were 612 discharges and 12 deaths at the hospital in 2002. Four patients took their own discharge against medical advice and appropriate procedures were in place to follow up, if deemed clinically necessary. Six patients became new long stay patients (continuous hospitalisation more than one year and less than five); two of those patients were aged 65 years or over.

There were 58 recorded accidents to patients at St. Mary's Hospital in 2002, 28 of these resulted in minor injury and none were deemed serious. Of the 29 recorded accidents to staff, 12 involved minor injuries and two were deemed serious. There were 80 recorded assaults on patients by other patients none of which were deemed serious. Of the 104 recorded assaults on staff, 22 resulted in minor injury and nine were deemed serious.

Six patients were placed on special nursing supervision in the hospital service in 2002 — a marked reduction from the previous year. There were 847 spans of special nursing supervision involving duty hours of ten hours or more.

In 2002, one patient was placed in seclusion at St. Mary's and there were 317 episodes of seclusion. The seclusion facilities at St. Mary's were not structurally appropriate, but these would improve with the re-location of patients to the new, high-support residence and acute unit. The 15-minute nursing observations should record when seclusion commenced and terminated. A multi-disciplinary review should be completed and documented for each episode of seclusion and should include the patients', doctors' and nurses' views about the seclusion episode. In all cases where seclusion was used on a reasonably continuous basis with the same patient, frequent multi-disciplinary reviews should be completed. There should be a clear distinction between seclusion and 'time out' which was an entirely different approach to care. 'Time out' should form part of a challenging behaviour programme which enabled the patient to achieve positive goals and well as reducing unwanted behaviour within a safe and therapeutic environment and should only be used as part of a planned approach to managing a difficult or disturbed patient. All patients in seclusion should have an unrestricted view of a clock from the seclusion room.

There was no notice informing patients of their rights under the Mental Treatment Act, 1945, or providing them with information on the local complaints procedure or on hospital charges; this issue needed addressing in the light of the re-location of acute services. Similarly, a hospital brochure with information relating to a patient's stay in the new acute unit should be produced.

There were no research projects governed by the Clinical Trials Act, 1987-1990 undertaken in the Mayo psychiatric service. No formal complaints/appeals were made to the local complaints officer during 2002. The 13 requests made under the Freedom of Information Act appeared to have been dealt with satisfactorily.

During 2002, 45 patients were prescribed ECT in the Mayo mental health service compared to ten the previous year. There was a dedicated ECT suite comprising separate waiting, treatment and recovery areas at the new Department of Psychiatry, Mayo General Hospital. The newly-appointed consultant in later-life psychiatry had assumed responsibility for the ECT clinic. The consent form and pre-ECT nursing checklist presently in use were satisfactory; these will all be reviewed in the context of the re-location of the clinic. Information leaflets on ECT, which enabled patients to make an informed decision regarding the appropriateness of this treatment, were available. Prior to the completion of the consent form, medical practitioners confirmed that they had explained to the patient the nature, purpose and likely outcome of ECT treatment. Records of the assessment of the patient's clinical status following each ECT session should be recorded in the medical notes. An ECT post-treatment nursing observation chart should also be introduced.

The standard of medical note-taking within the entire service was variable. Newly-admitted patients had a full medical evaluation which included admission notes, mental state examination, physical examination and clear immediate management plan appropriately recorded in all notes examined. Medical inputs in some notes examined in the long-stay areas of St. Mary's Hospital were not satisfactory. For example, at Ward 7, one case note had one medical entry for 2002 and one medical entry for 2003. There was provision for

the recording of the patient's name on each continuation page but, as mentioned in previous reports, this was not always recorded. Doctors making entries in medical notes should write their name in capitals, sign the entry and record his/her designation: this would ensure identification of the practitioner in the future. There was provision in the clinical notes for the recording of drug allergies, drug sensitivities. However, this section was not completed in most of the notes examined. The notes should also contain written evidence of discussions held with patients relating to their planned discharge from the hospital.

In the context of the re-location of services from St. Mary's Hospital, there was a draft document setting out the philosophy and model of care delivery for the service as a whole. In tandem with this, each component within the Mayo mental health service would have a written statement which described what the unit set out to do and the manner in which care was provided.

The Department of Later-life Psychiatry commenced providing services in 2002 and there were 102 persons on the register at the end of the year. There were a total of 109 admissions to the St. Anne's Unit, 23 of these were first admissions. This service will have access to four beds in the new acute psychiatric unit and will utilise the St. Anne's Unit at the Sacred Heart Hospital as an inpatient assessment and continuing care unit for persons with organic illness.

All policies, procedures, protocols and guidelines had been reviewed by the policy review committee, but had not been issued into general circulation due to the imminent re-location of services to new facilities. An audit programme should be developed which would ensure there was a system of checking policy, procedure and guideline compliance and validity.

A number of prescription cards and drug administration cards were examined. While most prescriptions were signed and dated individually, some of the signatures of the prescribers were not very legible. On a number of prescription cards examined, particularly in the admission unit, the number of discontinued prescriptions exceeded the number of current prescriptions, putting an increased risk of error in drug administration. All of these prescription cards should be rewritten. The drugs policy and procedure had been reviewed and the revised policy would be introduced in tandem with the relocation of services to the general hospital and community facility.

The standard of nursing documentation within St. Mary's itself using the 'Roper' model of nursing was of variable quality. However, a new nurse care planning system had been introduced at the St. Theresa's Unit incorporating the 'Tidal' model. This model focussed on understanding the present situation of the person, which included the relationship with illness and health rather than engaging with the disorder or illness. This was the first step in re-emphasising the relationship between patients and their carers and reflected the involvement of patients in planning and making choices and decisions about their own care and treatment. The nursing component of the clinical notes comprised a dedicated

booklet for recording historical and personal data assessment details, progress notes, nursing interventions and a discharge checklist. A member of staff had been assigned exclusively to the unit to facilitate staff training relating to the ongoing implementation of the revised nursing care plan. Once this care plan was fully operational at the acute psychiatric unit, consideration would be given to rolling it out to other appropriate inpatient care areas.

A nurse care planning system using the every day living skills inventory (ELS) should be considered as part of the rehabilitation process for many long-stay patients currently residing in St. Mary's Hospital.

Three female patients were interviewed in the admission unit to assess their opinion of the psychiatric services provided: all were of voluntary status. All patients were pleased with their reception at the unit; were introduced to their consultant psychiatrist and the unit nurses. Two patients had the nature of their illness explained to them, as had the effects and the potential side effects of their prescribed medication. However, one patient would have appreciated written literature on these subjects. One patient had not had her illness or medications explained to her, although she has been seven weeks in hospital. Two patients had been informed about their rights under mental treatment legislation but hadn't been told about any complaints procedure. All patients were satisfied with the activity programme, which provided a range of high-quality therapeutic interventions which patients found helpful. All three patients were critical of the standards of cleanliness and hygiene of the bathroom and toilet areas. One patient felt that the unit was rowdy and upsetting at times, but accepted that this was not the fault of the nursing staff. When asked for their suggestions for the improvement of the services provided, one said she would appreciate the availability of a dispensing machine for coffee, tea, drinks etc. One patient said that she said she would like to see visitor facilities improved.

RECOMMENDATIONS

It is recommended that:

1. The intensive care unit be closed and patients transferred to the high-support residence, Ashling as a matter of urgency.
2. The acute unit in the General Hospital be opened without delay and appropriate operational policies and procedures be put in place.
3. When the acute unit opens, the work already commenced on the refurbishment of St. Theresa's Unit be accelerated to allow it to take on its rehabilitation function.
4. A specialised rehabilitation team be recruited.
5. A team specialising in the psychiatry of intellectual disability be appointed.
6. Acute day hospitals be set up in the sectors.
7. The outreach and home-based facilities being introduced in the Claremorris sector be extended to all sectors.

ROSCOMMON MENTAL HEALTH SERVICE — 2003 INSPECTION

INSPECTED ON 16 JULY and 27 AUGUST 2003

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 52,726 was divided into three sectors as follows:

Sector	Population
Boyle (North)	18,865
Castlerea (Mid)	17,094
Roscommon (South)	16,767

IN-PATIENT CARE

In-patient care was provided at the 30-bed acute psychiatric unit in Roscommon General Hospital and community-based services were supplied in the sectors.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	3	5	—	1	10	100
3-12 Months	—	—	—	—	—	—	—	—
1-5 Years	—	—	—	—	—	—	—	—
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	1	3	5	—	1	10	—
% of Total	—	10	30	50	—	10	100	—

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	4	—	4	1	1
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
—	—	—	—	—	10

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	9	5	14
Temporary	1	—	1
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	10	5	15

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
387	7.3	87	22.5	89.4	10.6	392	—

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	16	848
Day Centres	6	153	264
Out-patient clinics	7	222*	651

*No. of out-patient clinics held in 2002

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
—	—	6	52	1	15

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
8.38	19	119	89.22	8

COST

The cost of the Roscommon Mental Health Service was €12.6 million in 2002.

GENERAL COMMENTS

With a catchment population of just over 50,000 and an annual cost of over €10 million the Roscommon service illustrated the difficulty in providing a cost efficient comprehensive multi-specialist service for such limited populations. Looking to the future, a good case could be made for the amalgamation of the East Galway and Roscommon services, with a joint acute admission unit at Portiuncula Hospital. The Inspectorate had suggested sharing services in the sub-specialties of later-life, rehabilitation and the psychiatry of intellectual disability with adjoining catchment areas. However, this had not, so far, materialised. The need for them was evidenced by the presence of the 34-bedded later-life unit in Aras Naomh Chaoilin and by the fact that one third of the residents in the Knockroe residence suffered from intellectual disability: this later difficulty was Board-wide as there was just one speciality consultant in the West of Ireland.

Other personnel deficits included lack of sufficient social workers and psychologists to staff full multi-disciplinary teams in all three sectors. There were comparatively generous

nursing staff allocations, in some cases amounting to over staffing. For example, the Inspectorate did not understand why two staff were required to supervise seven sleeping patients at night in the Renbracken residence.

On the physical resources side, there was a shortage of day hospitals; none in either the Boyle or Castlerea sectors, although both had day centres. There was a suitable premises in Castlerea currently used for mental health purposes which could more appropriately be adapted to serve as a day hospital. Such an initiative was needed to reduce the high admission rate from this sector. The acquisition and opening of the Roscommon day hospital in September 2002 was a step forward. The Inspectorate was surprised to hear of the difficulty experienced in sourcing adequate staff for this operation, given the generous number of nurses in the service. The sector had identified a suitable site at St. Coman's Park, Roscommon, for a purpose-built larger day hospital premises capable of giving a truly acute service. The Inspectorate was given a planning brief relating to this and had a concern that none of the interior areas were large enough to accommodate truly ill, acutely disturbed patients. The Inspectorate welcomed the enthusiasm that the team had brought to the operation of the new premises which did try to cope with acutely ill persons and thereby prevent admission or reduce length of stay. A number of houses had been sourced by the Roscommon Mental Health Association and the service to serve as rehabilitation residences for patients needing a high degree of support. These had been turned down on health and safety grounds. However, one on the Dublin road had been identified and was awaiting assessment. The Inspectorate was told that the day centre at Ballaghadereen was overcrowded with 35 daily attendees and either enlargement or additional accommodation was required in relation to this operation.

The Aras Naomh Chaoilin premises at Castlerea had been most valuable in facilitating the closure of St. Patrick's Hospital. However, its functions should now be examined. While the care of the elderly was necessary to take elderly patients from St. Patrick's it now had little psychiatric content and mainly served as a nursing home for the elderly. Perhaps this function might be better served by the generic elderly services with which the unit had no relationship. As far as younger persons were concerned, the need for continuing, rehabilitative community care was evident and badly needed.

The Knockroe or Byron House in Castlerea was the only high-support residence in the service and one third of its capacity was taken up by intellectually disabled persons for whom no appropriate accommodation was available. Negotiations with the Learning Disability Service had been ongoing for 12 years in regard to these patients, without success. This was unacceptable.

The in-patient unit at Roscommon was pleasant but seldom operated at full capacity, despite the high admission rate of the service. This brought into question the economics of an independent service for such a small catchment area. A plan had been drawn to provide a close observation area of seven beds, which seemed to the Inspectorate to be too extensive for need and ran the risk, if not carefully managed, of creating a ghetto within the unit.

The unit, as elsewhere in the service, was generously staffed. A graded system of patient observation had been introduced to reduce the high level of one-to-one nursing that had characterised the service up to now. This included a system of graded levels including 15-minute observation graded “red code”. There was an admission policy to reduce the high admission rate. All non-elective potential admissions were routed through A&E for assessment by a junior doctor who then conferred with the appropriate consultant and a decision to admit or not was then made. Temporary admission orders were made by consultants and most admitted patients were seen by a consultant within 24-hours of admission, including at week-ends. As far as possible, attempts were made to provide a primary nursing care system in the unit.

There were 41 involuntary admissions to the Roscommon mental health service in 2002, five were on PUM admission forms and the remainder were admitted on temporary certificates. Seven patients admitted on temporary certificates were re-graded to voluntary status and nine patients admitted as voluntary patients were re-graded to involuntary status during their hospital stay. There were no extensions of temporary admission orders or deaths in the Roscommon mental health service in 2002. Eleven patients took their own discharge from the hospital against medical advice. Procedures were in place to follow up those patients if deemed clinically appropriate. One patient was transferred from the acute unit Roscommon General Hospital to St Brigid’s Hospital in Ballinasloe, under Section 206 of the Mental Treatment Act, 1945. The patient remained at St Brigid’s Hospital in Ballinasloe at the time of this inspection.

There were 293 consultant-led liaison consultations in the Roscommon service in 2002, resulting in 11 admissions to the acute psychiatric unit and a further 114 referred to the mental health service out-patient department.

The facilities for the administration of ECT at the acute psychiatric unit were satisfactory and nine patients were prescribed ECT during 2002. There were 154 episodes of special nursing supervision involving duty spans of 10-hours or more in 2002 and 20 patients were placed on one-nurse to one-patient special nursing supervision.

There were no complaints made by patients, or patients’ relatives to the local complaints manager in 2002 and two requests were made under the Freedom of Information Act, 1997; these appear to have been dealt with satisfactorily. All patients, irrespective of their status, must be informed of their rights. However, there appeared to be no formal system of informing patients of their rights under the Mental Treatment Act, 1945. An advocacy service had been introduced in this service, which was in its infancy. The giving of information on rights especially to patients admitted on involuntary treatment forms should be adequately recorded in the patient’s case notes. There were no research projects governed by the Clinical Trials Act, 1987-1990 undertaken in this service.

There were 10 recorded accidents to patients, five resulted in minor injury and two were deemed serious. There was one recorded accident to a staff member in 2002 resulting in minor injury. There were 13 recorded assaults on patients by other patients and 11

recorded assaults on staff and none were deemed serious. The procedure in place for the documentation of accidents and assaults to patients and staff was satisfactory.

Out-patient clinics were suitably located at seven centres throughout the county and 651 patients attended of whom 165 were first time attendees. Referral to the clinic was through the local general practitioners and an appointments system was in operation. Clinics within the Boyle sector were held bi-monthly and within the Roscommon sector were held weekly. There was a waiting list, but all referrals were prioritised by the consultant according to need. The facilities at the Boyle out-patient clinic needed improvement.

The family placement or foster care scheme provided bed and breakfast and evening meals for patients from Monday to Friday with full-board provided at weekends. This scheme had been introduced to facilitate the early closure of St Patrick's Hospital in Castlereagh. The scheme was reviewed and a report produced in 2000. The review highlighted a number of issues relating to inadequate information on patient's diagnosis, explanation regarding mental illness, medication management and possible side effects, inadequate support from the service for respite relief, lack of structure for recreational activity and community integration especially at weekends and dissatisfaction with funding arrangements. Some residents as part of their review expressed dissatisfaction with placements some distance from the nearest town where the lack of public transport meant that they had to rely on the service provider to take them out. While this scheme was supervised by a CNMIII, an annual report should be produced and forwarded to the management team in order to ensure that this system was kept under constant review. It was noted that no new patients were being referred to the scheme and alternative accommodation had been requested in service plans. A respite bed was provided in Tithe na gCarad for up to one month.

A newly-established quality circle group was reviewing all policies, procedures and protocols relating to service delivery. The existing policy manual had several policies, procedures and protocols in place some which originated from the Western Health Board and others unit specific. Policies relating to staff absenteeism, sick leave, annual leave etc. were staff matters and should be kept separate from policies, procedures etc. relating to the clinical care of patients. A computerised index of all policy documentation should be kept. Guidance notes should be produced for staff on the management of illicit drug use or drug-related incidents. The policy relating to patients absent from the hospital without official leave should be reviewed, to include a named person with responsibility for the co-ordination of the search and contacting the Gardai and patient's relatives. There was a need for a smoking policy and a designated smoking area should be provided. This was currently in the sitting room with non-smokers availing of the conservatory.

The nursing care plan comprised historical and personal data, assessment details, a plan and intervention section and all were well completed. Nursing records examined reflected the involvement of patients in planning and making choices and decisions about their own care and treatment. All entries in nursing records were accurately dated and time of entry recorded using the 24-hour clock. The biographical data sheet for each admission was completed very satisfactorily and there was a statement in the nursing assessment giving a physical description of the patient.

The medication prescription charts were audited by the quality circle group in January 2003 and a number of recommendations made. Following on from this, good practice guidelines on documentation for the prescribing and administration of medication had been introduced and were under review by the management team. Prescriptions examined were legible and contained one date and one signature for each prescription. The drug administration recording card had provision for the nurse's signature in full and this was completed satisfactorily. A number of prescription cards had a greater number of discontinued prescriptions than current prescriptions and these should be rewritten to reduce the risk of drug error.

Clinical documentation was inspected and it was noted that case-note structure and composition was of reasonable standard. However, there was little evidence of comprehensive multi-disciplinary intake assessment accompanied by a detailed treatment and management programme of care in which the patient had a partnership role. The outcome of such assessment should lead to a tentative ICD diagnosis coded on the top sheet as well as in the clinical text. Examination did not always support the information that consultants always signed temporary orders.

RECOMMENDATIONS

It is recommended that:

1. The future of the operation and use of the Aras Naomh Chaolin premises be reviewed. The future role for the elderly patients residing there should be considered in conjunction with the generic service providers in the context of the rationalisation of specialist psychiatric services for the elderly.
2. Development of specialist services for the intellectually disabled and rehabilitation in the Boards functional area should be extended so that those services are available to the Roscommon population.
3. An in-depth service review be undertaken to increase the efficiency of staff resource deployment.
4. The strengthening of the services, human and physical resources for the Castlerea sector and their proper exploitation to decrease the high admission rate from this sector.
5. Day hospitals be set up in the Boyle and Castlerea sectors and a larger premises be acquired for the Roscommon operation.
6. Mental health centres and sector headquarters be established in all sectors.
7. Additional social work and psychology personnel be recruited to provide truly multidisciplinary service in all sectors.
8. The family placement service should be reviewed annually and a written report provided for the Board.

CHAPTER TEN

Registered Psychiatric Hospitals

ST. PATRICK'S HOSPITAL — FIRST 2003 INSPECTION

INSPECTED ON 24 JUNE 2003

GENERAL DESCRIPTION OF SERVICE

St. Patrick's Hospital was a single specialty, stand alone private hospital which admitted private patients from the entire country. In addition to acute care, the hospital provided a number of sub-specialty programmes for hospitalized patients and, more recently, day care.

IN-PATIENT CARE

In-patient care was provided in one male, two female and six integrated units which had a total of 251 beds.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	5	67	50	14	7	143	91.6
3-12 Months	—	1	—	1	1	2	5	3.2
1-5 Years	—	—	1	1	1	1	4	2.6
> 5 Years	—	—	—	2	1	1	4	2.6
All Lengths of Stay	—	6	68	54	17	11	156	100
% of Total	—	3.8	43.6	34.6	10.9	7.1	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
8	29	—	47	45	5
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
3	16	3	—	—	156

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	118	89	207
Temporary	7	—	7
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	125	89	214

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
2,831	—	—	—	98.2	1.8	2,847	3

COMMUNITY FACILITIES**Day Facilities**

	Number	No. of Places	No. of persons attending
Day Hospitals	—	—	—
Day Centres	—	—	—
Out-patient clinics	1	340*	1,213

*No. of out-patient clinics held in 2002

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
24	38	172	109	21

GENERAL COMMENTS

St. Patrick's Hospital had been extensively refurbished in recent years and this had resulted in a very high standard of patient accommodation. Facilities at the hospital included acute hospital care; specialised care for older persons, young persons, persons with eating disorders and persons with mood disorders. A new facility for people with memory difficulty was established since the last visit of inspection. This memory clinic was a one-stop-shop where, in the course of a single day, comprehensive assessments were carried out. The service was provided by professional staff from the disciplines of neurology, neuro-psychology and psychiatry who conducted separate examinations and conferred before a diagnosis was made. This was followed by a feedback session for the person and their carers or relatives some days after the initial assessment. There were also plans to establish a day hospital at St. Patrick's Hospital. A considerable number of patients attended the eating disorders programme as day patients, rather than in-patients: this new arrangement appeared to be working well.

Emmet Ward, which was the mixed, long-term, high-dependence 24-bedded unit, had closed since the last visit of inspection. The majority of the patients on this ward were

public patients funded by the Eastern Regional Health Authority and most of these patients had been re-located to nursing home accommodation. As part of the re-location of the long-stay patients, the number of patients on Sheridan Ward had reduced from 20 on the previous visit to eight. All of these eight patients were long-stay and some were in the high-dependence category. There were plans to close this ward.

The overall physical facilities at St. Patrick's Hospital were of a high standard. Ceiling to floor bed screens in multi-bedded areas provided adequate privacy for patients. All bathroom and sanitary facilities were clean and well-maintained and most single rooms had en-suite facilities. All patients had reasonably free and easy access to a well-stocked hospital shop and to the coffee shop.

There were 15 nursing vacancies at St. Patrick's Hospital on the day of inspection. Recruitment of qualified nursing staff remained a major challenge.

In 2002, 50 patients were admitted to St. Patrick's on involuntary certificates and none had their involuntary admission forms extended. Information relating to patients admitted as involuntary patients being re-graded to voluntary or visa versa was not available.

There were 837 accidents to patients at the hospital in 2002, four resulted in minor injury; none were deemed serious. There were 46 accidents to staff, 43 resulted in minor injuries and one was deemed serious. There were no assaults on patients by other patients. There were 46 assaults on staff, 25 resulted in minor injury and one was deemed serious. The accident and incident reporting system was satisfactory.

Statistical information on the number of complaints made by patients or their relatives to the local complaints manager was not available. The St. Patrick's Hospital Patient Charter, which included information for patients on how to make a complaint, was prominently displayed at all locations. Information on patient rights' under the Mental Treatment Act, 1945 should be included in a revised and updated Charter.

There were no research projects governed by the Clinical Trials Act, 1987-1990 undertaken in St. Patrick's Hospital and seclusion was not used in the hospital. During 2002, 18 patients took their own discharge from the hospital. Follow-up procedures were in place if deemed appropriate.

There was a dedicated ECT suite, comprising of treatment and recovery rooms and a named consultant psychiatrist responsible. All ECT documentation was satisfactory. Prior to the completion of the consent form, the staff doctors indicated that they had explained to the patient the nature and purpose of the treatment. There was a pre- and post-ECT nursing checklist, which was appropriately completed for each patient. In addition, an information fact sheet with pertinent information for patients and relatives relating to ECT was made available prior to a course of ECT treatment. There was an appropriate induction process for all new doctors relating to ECT, under the supervision of a consultant psychiatrist.

The nursing records examined contained relevant information relating to the observation of the patient and changes in the patient's condition. Nursing documentation was integrated into the clinical files. All entries were accurately dated and signed, but some of the signatures were not legible. The biographical data sheet for each admission recording legal status, next-of-kin, name of GP, history of allergies and other relevant information were well completed. The records should reflect the involvement of patients in planning and making decision about their care and treatment. The Inspectorate welcomed the 'client problems and care needs' form recently introduced which was completed by patients, highlighting problems that they wanted addressed while in the care of St. Patrick's Hospital. The patients agree to adhere to a treatment plan to meet their own objectives.

Each ward within St. Patrick's Hospital had a written statement setting out the purpose and function of the unit and the manner in which care was provided: this statement was available in a form that was accessible to patients and their families.

The quality steering committee at St. Patrick's Hospital continued its work in relation to the development of patient-centred hospital standards. A number of audits relating to ECT, prescription medical card, clinical notes, discharge documentation, complaints, consumer survey, and waiting lists were under way at the time of inspection. The Inspectorate welcomed this initiative. The Inspectorate also welcomed the fact that the audit process was seeking feedback from service users. The 'Buddies' Group for men living alone (widowed, separated and single men) which was established to respond to the problems of male suicide, was not well attended and never really evolved. Other programmes such as the depression programme that commenced in April 2003 and was designed to meet the needs of individuals who were suffering from depression appeared to be working satisfactorily.

At the time of this visit all policies, procedures and protocols were under review. Ideally, each policy, procedure and protocol should have a multi-disciplinary focus. All revised and updated policies should be formally introduced to relevant staff ensuring awareness and understanding of content.

The written policy for the ordering, prescribing, storing and administering of medicines was under review. The quality of prescription writing was variable on a number of individual prescriptions checked by the Inspectorate. There was a high risk of incorrect drug administration in a number of cards where discontinued prescriptions were greater in number than current prescriptions. The system of drawing a line through discontinued prescriptions and not signing and dating that they had been discontinued was also a serious risk factor. All prescriptions were signed and dated individually, which was satisfactory. The drug administration recording card had provision for the nurse's signature and initials. As abbreviations were noted in cards examined there was a need for a list of approved abbreviations. Abbreviations were noted in relation to drug interactions and drug allergies in the prescription cardex. The layout of the prescription card was satisfactory.

Two patients, one teenager and one middle-aged male, randomly selected, were interviewed to assess their opinion of the services provided. Both were voluntary and had

previous admissions. Both were satisfied with the courtesy and helpfulness of staff, were introduced to the professional team responsible for their care and knew the name of their consultant psychiatrist. They were pleased with the frequency of consultations with their consultant psychiatrist and the ease of accessibility to them. One patient was especially pleased with her contact with the psychologist and she felt she was always treated with dignity. As regards their psychological problems, both felt that these had been fully explained to them, as were the medications prescribed. Both patients were satisfied with their involvement in their care plan and both knew the name of their primary nurse. However, one patient mentioned that it was difficult to establish a meaningful therapeutic relationship with the nurses as they changed frequently. Both patients were happy with the activities provided in the form of art and crafts, recreational and therapeutic activities. One patient was unhappy with the quality of the food provided. One patient had received a booklet about the hospital and was aware of his rights' under the Mental Treatment Act, 1945. He was also aware of a complaint procedure.

The continued registration of the hospital under the Mental Treatment Act, 1945 was recommended.

ST. PATRICK'S HOSPITAL — SECOND 2003 INSPECTION

INSPECTED ON 17 NOVEMBER 2003

GENERAL COMMENTS

St. Patrick's Hospital was a free standing private, single specialty, mainly acute hospital and therefore it was running against the national policy in the public sector of providing acute psychiatric inpatient care in general hospital units. It drew patients from the entire country and provided a number of sub-specialty services, for example, for eating disorders, although this was moving more in the direction of a day rather than an inpatient programme. The hospital had now reached agreement with the main private health insurance company on the details of a day hospital programme and part of the hospital was being adapted to provide the accommodation for this initiative. A post of manager for the programme was being established and an additional consultant was being sought to oversee the medical aspects of the scheme.

St. Patrick's Hospital had links with the Area 3 service and provided staff for the community aspects of that service and, in addition, accommodated the workshop for that service in St. Patrick's itself, as well as the Martha Whiteway day hospital for the later-life service of Area 3. Some of the consultant psychiatrists of Area 3 had offices in St. Patrick's Hospital. The Inspectorate felt it would be better if these links were severed and the Area 3 service became independent of St. Patrick's Hospital. In particular, the general campus of St. James's Hospital would be a more suitable setting for the later-life day hospital.

In common with some psychiatric services, St. Patrick's Hospital admitted alcohol dependent persons for detoxification and after care. The Inspectorate was of the view that routine detoxification was better carried out in primary care and that severe dependence

with the risk of severe withdrawal symptoms was better and more safely effected in general medical wards.

There were very considerable refurbishments and improvements in the hospital, which brought the standard of comfort and safety to a very high level and reflected very favourably on the management. Some of these improvements, as in the case of the new Dean Swift Ward, had been of an imaginative and innovative kind from the design point of view. There were also other praiseworthy initiatives, in the area of primary nursing, nursing care plans, discharge planning groups, patients' council and patients' charter of rights. All in all, within the concepts of its orientation and function the hospital provided a very high standard of patient care and comfort.

ST. EDMUNDSBURY HOSPITAL, LUCAN, CO. DUBLIN — FIRST 2003

INSPECTION

INSPECTED ON 31 MARCH, 2003

GENERAL DESCRIPTION OF THE SERVICE

St. Edmundsbury was built in the reign of George III on land belonging to the first Viscount de Vesci of Lucan House, who was a friend of Dean Swift; hence its intimate association with St Patrick's Hospital. In 1898, St. Edmundsbury was purchased by St. Patrick's Hospital. In 1986, a new wing was built to accommodate fifty patients and the original house was refurbished as an activity and therapy area.

IN-PATIENT CARE

In-patient care was provided with a total of 50 beds.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	9	7	2	2	20	100
3-12 Months	—	—	—	—	—	—	—	—
1-5 Years	—	—	—	—	—	—	—	—
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	—	9	7	2	2	20	100
% of Total	—	—	45.0	35.0	10.0	10.0	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	4	—	8	6	2
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
—	—	—	—	—	20

Status of In-Patients on date of First Inspection 2003

Status	Male	Female	Total
Voluntary	11	35	46
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	11	35	46

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
498	—	—	—	100	—	503	—

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
*	5	16	8	2*

*Included in the statistics for St. Patrick's Hospital

GENERAL COMMENTS

St. Edmundsbury Hospital, founded in 1898, was a private hospital specialising in the treatment of psychiatric disorders. The new building contained 44 single bedrooms and three double bedrooms, all en-suite. In addition, there were two extra bathrooms. There was also a clinical room, a nurses' office, a tea room and a hairdressers' room. The old building was used mainly for therapies, and also contained the patient and staff dining areas. The consultant psychiatrists, the psychologist, the family therapist, the occupational therapist and the cognitive behaviour therapist had their offices here. There was also a small, four-bedroom nurses' residence. There was an occupational therapy department, a sitting room, a music room, a coffee dock and a beauty therapy unit.

Staffing consisted of two full-time and three part-time consultants, a full-time psychologist, a full-time and part-time occupational therapist, a full-time nurse (qualified as a family therapist) and another nurse (qualified as a cognitive behaviour therapist) worked two and a half days here and the remainder of the week at St. Patrick's Hospital. Quite a number of the patients were taxed to St. Patrick's for special therapeutic programmes,

for example electroplexy, mood disorders, cognitive behaviour therapy etc. There were two NCHDs attached to this service and GP cover was provided by local practitioners from the Lucan area. An assistant director of nursing, two clinical nurse managers Grade II, seven staff nurses and six care staff provided nursing cover.

On the day of inspection, there were 46 patients in residence in the integrated new building, 35 females and 11 males. During 2002, there were 498 admissions, 367 female and 131 male. On the previous inspection there had been interesting programmes for patients suffering from ME (Myalgic Encephalomyelitis), but medical insurers were reluctant to continue subvention because of the length of time treatment had taken.

The standard of décor, hygiene and patient care were high. There was a high-quality fire-alarm system in use, which was inspected by the fire officer attached to St. Patrick's Hospital.

The continued registration of St. Edmundsbury Hospital, under the Mental Treatment Act, 1945, was recommended.

ST. EDMUNDSBURY HOSPITAL, LUCAN, CO. DUBLIN — SECOND 2003

INSPECTION

INSPECTED ON 17 DECEMBER 2003

GENERAL COMMENTS

St. Edmundsbury Hospital continued to be a short-stay hospital with an average length-of-stay of 29 days. It catered for the entire country and was affiliated to St. Patrick's Hospital, Dublin.

There were 36 patients, 30 female and six male, in the 50-bed hospital on the day of inspection: all were of voluntary status. In 2004, the number of consultants servicing the hospital would increase to three, with a new appointee in the field of recalcitrant affective disorders. Likewise, the number of NCHDs would increase from two to three. Also in 2004, there would be two additions to the nursing staff.

There had been no substantial change to the hospital since the earlier inspection in March this year.

ST. JOHN OF GOD HOSPITAL — FIRST 2003 INSPECTION

INSPECTED ON 26 JUNE 2003

GENERAL DESCRIPTION OF THE SERVICE

St. John of God Hospital was a single specialty, stand alone private hospital which admitted patients from the entire country. In addition, the hospital provided 42 public in-patient

beds for Dublin South East (Catchment Area 1 and part of Area 2) which had its administrative headquarters at the Cluain Mhuire Service, Blackrock.

IN-PATIENT CARE

In-patient care was provided at this hospital with a total of 181 beds.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	2	25	35	15	9	86	91.5
3-12 Months	—	—	1	1	1	2	5	5.3
1-5 Years	—	—	—	1	—	—	1	1.1
> 5 Years	—	—	—	2	—	—	2	2.1
All Lengths of Stay	—	2	26	39	16	11	94	100
% of Total	—	2.1	27.7	41.5	17.0	11.7	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
7	21	4	29	13	3
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
—	16	1	—	—	94

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	53	76	129
Temporary	17	18	35
P.U.M.	—	—	—
Ward of Court	1	—	1
Total	71	94	165

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
1,316	—	562	42.7	95.3	4.7	1,305	2

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
12.5	18.94	81	65	19.34

GENERAL COMMENTS

The St. John of God Hospital, Stillorgan provided assessment, treatment, rehabilitation and on-going care of a high standard for people with mental illness in addition to the 42 public in-patient beds provided for Dublin South East. The East Coast Area Health Board had contracted two beds at St. John of God's Hospital for overflow patients from the nearby Vergemount Clinic serving Area 2.

The hospital had six integrated nursing units with a bed complement of 181 and accommodated 165 patients on the day of inspection; 35 were hospitalised on temporary certificates, one patient was a ward of court, 42 patients were public patients, one had been transferred from the Vergemount Clinic under Section 208 of the Mental Treatment Act, 1945 and the remainder were direct admissions from the Cluain Mhuire service. There were 27 admissions, involving 24 patients from Vergemount Clinic since the contract arrangements with the ECAHB commenced. This system appeared to be working satisfactorily.

The physical environment at the hospital was of a very high standard. This resulted from the continued development and upgrading and maintenance of the hospital and its grounds. The newly-built St. Joseph's Unit had increased from 28 beds to 32 beds with 18 beds in the unit remaining closed. The opening of St. Joseph's Unit facilitated the rationalisation of service provision within the hospital. St. Paul's Ward catered almost exclusively for public patients, but public patients were nursed in other wards of the hospital according to their clinical needs. The 16-bed adolescent unit which had closed a number of years ago due to staffing difficulties remained closed. The challenge in relation to the recruitment of registered psychiatric nursing personnel continued to improve gradually. With this continued improvement it was hoped to open the remaining 18 beds at the St. Joseph's Unit later this year.

St. John of God Hospital had a clear mission statement and a comprehensive and well laid out report for the hospital and its associated services was produced on a yearly basis. This report, with contributions from the heads of departments, set out achievements in the previous year and targets for the year ahead. This hospital was one of the few services in the country that produced a written Annual Report and the Inspectorate would recommend other services to follow this example.

There was a commitment to put an adolescent service in place and re-open the St. Anne's Unit. This was in addition to the commissioning of a further 18 beds at the St. Joseph's Unit and the complete refurbishment and re-modelling of the organisation of the St. Peter's admission unit. There were also plans at an advanced stage to seek an accreditation process with the CASPE research unit, which is UK-based.

With the opening of the four additional beds in the St. Joseph's Unit and the improved nurse recruitment and retention the waiting lists had been eliminated, which, in turn, facilitated the hospital in accepting emergency referrals on the day of request and other referrals within 24-hours. The allocation of identified consultant teams to certain units had also led to improved continuity of care and less disruptions to patients and staff. All of these changes were audited during 2002 and received positive feedback from staff.

Since the last visit of inspection, this service had completed a strategic development plan. Following on from this, there were plans to relocate the pharmacy and to redesign the high-dependence unit, with a view to providing an optimal setting for patients and staff safety and an improved therapeutic and recreational environment.

There were 1,702 admissions (includes 386 for Cluain Mhuire) to St. John of God Hospital in 2002; 62 were on temporary admission orders; two were aged 16 or younger. In 2002, four patients had their temporary admission orders extended. Also in 2002, 54 patients took their own discharge from St. John of God Hospital against medical advice. Procedures were in place to follow-up those patients, if deemed clinically appropriate.

There were 89 episodes of seclusion involving 22 patients in 2002, an increase from 39 episodes involving five patients in 2001. A seclusion register was maintained and 15-minute nursing observations appropriately recorded. Policy and procedure relating to seclusion was under review at the time of inspection. One of the rooms in use was not structurally appropriate and required ventilation and modernisation. There were plans to re-locate these high-observation facilities as part of the restructuring of St. Peter's Ward. There was adequate privacy for patients whilst in seclusion and access to the seclusion areas was through a small corridor adjacent to the nurses' station. All of the nursing and medical documentation relating to seclusion episodes were cross-referenced to the special seclusion register. A multi-disciplinary review was completed and documented for each seclusion episode.

One-to-one special nursing supervision, involving two patients, had been used in St. John of God Hospital on six occasions in 2002. There were no research projects governed by the Clinical Trials Act, 1987-1990 undertaken in the hospital. There was a complaints procedure available within the hospital, information on which was on public display at all wards. Requests under the Freedom of Information Act, 1997 were processed satisfactorily. There were four recorded complaints made by patients or patients' relatives to the local complaints manager during 2002. A system should be in place to ensure that there is adequate monitoring of all informal complaints in order to note any quality implications arising from the complaint.

There were 431 recorded accidents to patients and five recorded accidents to staff in 2002; none were deemed serious. Of the 55 recorded assaults on patients by other patients, 12 resulted in minor injury. Of the 75 recorded assaults on staff, 18 resulted in minor injury and none were deemed serious.

In 2002, 22 patients were prescribed ECT at St. John of God Hospital. There was a policy and protocol in place for ECT with a named consultant psychiatrist responsible for the ECT clinic. The pre- and post-ECT nursing checklist was appropriately recorded. Patients' vital signs were recorded pre and at regular intervals post ECT. On examination of medical notes the Inspectorate could find no evidence of a documented physical examination of one patient prior to ECT. Information leaflets were available to enable patients make an informed decision regarding the appropriateness of ECT. The leaflets contained information about the risks and benefits of ECT and the availability of alternative treatment.

A number of clinical files, selected at random, were examined. Newly-admitted patients had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and immediate management plan, appropriately recorded. The signature of the doctor making the entries in the notes was not always legible; designation of the doctor should be recorded. Time of entries should also be recorded. Written instruction on the filing of documentation within the record should be available and patients' names should be clearly recorded in each continuation page. Many files contained a substantial amount of loose clinical material. This should be reviewed.

While information on the rights' of detained patients was prominently displayed in in-patient care areas, there was a need to ensure that this information was brought to the attention of patients and to be satisfied that the patient understood his or her rights. The service intended giving this information, in writing, and had devised an appropriate patients' rights leaflet which will be used in conjunction with a verbal explanation of the contents.

The policy for the ordering, prescribing, storing and administration of medicines was under review. The standard of prescription writing was variable, with some scripted prescriptions difficult to read and not all prescriptions were signed in full. It was noted that the discontinuation column was not always completed. There was an increased risk factor of drug error in a number of cards where discontinued prescriptions were greater in number than current prescriptions: this required review.

Nursing care plans, using the 'Oram' model of nursing were appropriately recorded. The overall standard of nursing documentation examined was satisfactory. The system, using a stamp to record inputs relating to weekend leave, team review, care plan evaluation and level of observation was very satisfactory. The biographical data sheet for each admission was well completed and each nursing assessment gave a physical description of the patient. Following a review of the current 'Oram' model a new nursing treatment model, which involved an extensive review process and had an eclectic mix of nursing models had been introduced in a number of areas on a pilot basis.

All policies, procedures, protocols and guidelines were under active review at the time of inspection. Some had received executive approval and were ratified and implemented and it was hoped that all would be ratified and implemented by the end of 2003.

Some major work was carried out in respect of health and safety with an independent audit conducted in December 2002 and a hazard identification audit by the Hospital's insurers in April 2003. Information leaflets and policies were developed to focus on specific issues of health and safety.

Three patients were interviewed to assess their opinion of the psychiatric services provided; two males and one female. Two were of voluntary status and one was of involuntary status. Two of the patients found the medical and nursing personnel extremely helpful and were very pleased with the frequency of consultations. They were always treated with dignity and courtesy and found the ambiance of the unit excellent. Two patients felt that

the nurses appeared to be busy with paperwork and meetings rather than being involved on a personal level with patients. One patient was aware of his rights' under the Mental Treatment Act, 1945 and was also aware of his care plan and was pleased with the depth of his involvement with same. All patients were happy with the quality and quantity of the food provided. Also, all patients gave a high rating to the standards of hygiene in the unit.

One patient felt that the unit became boring after 6pm each day and at the weekends with only television for diversion. This was a sentiment expressed in practically all psychiatric hospitals throughout the country. Two patients expressed their dislike of being interviewed by doctors in the presence of other team members.

Overall, the professional care, furnishing, hygiene, and décor, at St. John of God Hospital were of a high standard and its continued registration under the Mental Treatment Act, 1945 was recommended.

ST. JOHN OF GOD HOSPITAL — SECOND 2003 INSPECTION

INSPECTED ON 10 DECEMBER 2003

GENERAL COMMENTS

St. John of God Hospital, Stillorgan provided in-patient care for private patients from the entire country and for patients from the Cluain Mhuire catchment area (Area 1 and part of Area 2) who required in-patient care. There had been no major changes in the hospital since our earlier inspection this year. St. Joseph's, the newly-opened admission ward, was functioning well and it was hoped to bring the additional unopened 18 beds into use as soon as possible. These will cater for some special problems, such as eating disorders as well as additional general beds. It was also hoped to reopen the adolescent unit, currently closed, with the appointment of a consultant, the current post holder having retired. The hospital continued to provide a high standard of in-patient care to its patients.

There were 147 patients in the hospital on the day of inspection: nine were hospitalised on temporary certificates, 50 were public patients from the Cluain Mhuire catchment area service. St. Paul's ward served as the admission unit for the Cluain Mhuire catchment area and St. Joseph's ward served as the admission unit for private patients. St. Raphael's unit, Carrigdubh and Carrigfergus, catered mainly for the organic and functional elderly patients. The St. Camillus ward catered for acute psychiatry, rehabilitation and an alcohol treatment centre. St. Peter's ward was the closed ward for more seriously ill patients. The seclusion facilities were located in this area. A day hospital for the Cluain Mhuire catchment area was incorporated on the ground floor of the hospital adjoining the OT department.

Seclusion procedures and documentation were checked on the first inspection. The seclusion register was examined on this occasion and the signature for some of the authorisations was not legible. In addition, some authorisations contained initials only. However,

a signature bank was retained in order to identify the practitioner in the future. Ideally, all seclusion authorisations should be signed in full and designation stated.

The standard of medical and nursing documentation was high. This resulted from ongoing quality and audit initiatives. The hospital had a written mission statement, which clearly identified goals and objectives for care delivery. All policies, procedures and guidelines had been reviewed and updated since the previous inspections earlier in the year.

BLOOMFIELD HOSPITAL, DONNYBROOK — FIRST 2003 INSPECTION

INSPECTED ON 1 APRIL 2003

IN-PATIENT CARE

In-patient care was provided with forty-five beds in two integrated wards.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	—	—	—	2	2	4.6
3-12 Months	—	—	—	3	5	5	13	30.2
1-5 Years	—	—	1	1	5	8	15	35.0
> 5 Years	—	—	—	2	3	8	13	30.2
All Lengths of Stay	—	—	1	6	13	23	43	100
% of Total	—	—	2.3	14.0	30.2	53.5	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
17	15	2	3	—	—
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
—	6	—	—	—	43

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	20	16	36
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	20	16	36

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
16	N/A	N/A	N/A	100	—	0	12

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
—	4	21	10	—

GENERAL COMMENTS

Over recent years, the numbers of patients accommodated at Bloomfield dropped to approximately 50% of its original complement of 60. This was due to the increasing cost of maintaining patients and also the difficulty in recruiting nursing and care staff. Eventually, it was decided to sell the entire complex for development purposes and with the proceeds build one purpose-built unit at Stocking Lane, Rathfarnham. Negotiations were at a delicate stage at the time of inspection, but it was expected that the deal would be completed within the coming months. A complication had arisen from the fact that a preservation order had been placed not only on the Emmet House component of the complex but also on two wards, St. Martha's and St. Luke's and this would limit building developments. In addition, a number of local residents were objecting to any new development.

There had been no significant developments since the previous visit. There were 36 highly-dependant patients in residence on the day of inspection, 20 males and 16 females; one was a ward of court and the remainder were of voluntary status. The medication supply and supervision was under the care of a local pharmacy. There was very little therapeutic activities as the patients were too elderly, however, there were musical evenings and two voluntary groups visited on a regular basis. Patients had a splendid conservatory from which they could admire the well-kept grounds and gardens.

While two wards were in use, the ground floor was used mainly as a dormitory area and, by day, the upstairs ward became an integrated area. Staffing consisted of a Matron, Deputy Matron, one CNM II with ten nursing aides by day and one staff nurse and two aides by night. In addition to the Medical Superintendent, there were two visiting psychiatrists and a physiotherapist on call.

The case notes examined were well completed and blood checks were made on a very regular basis. Fire drill was carried out twice yearly. There was a nursing policy and procedure book and staff has been trained in lifting techniques and control and restraint procedures. There were individual care plans and nurses made inputs by day and night.

The continued registration of Bloomfield as an approved institution under the Mental Treatment Act, 1945 was recommended.

BLOOMFIELD HOSPITAL, DONNYBROOK — SECOND 2003 INSPECTION

INSPECTED ON 2 DECEMBER 2003

GENERAL COMMENTS

Bloomfield had been sold to a developer who had provided a new site and was building a replacement 35-bed hospital in Rathfarnham. It was anticipated that the move to the new hospital would take place in early 2005.

The hospital comprised two integrated units, St. Martha's and St. Luke's. However, St. Luke's unit was used only as sleeping accommodation, while St. Martha's unit, in addition to providing sleeping and day accommodation for its own patients, also provided day accommodation for patients from St. Luke's. The sleeping accommodation in St. Martha's unit was provided in single rooms and one three-bed room. The sleeping accommodation in St. Luke's unit was provided in double, three-bed and four-bed rooms, and one six-bed unit. Patients remained in the day area all day.

There were 37 patients on the day of inspection, 23 male and 14 female; all were of voluntary status. Staffing consisted of four trained nurses and nursing assistants by day and two staff on each ward at night.

The general standard of accommodation and care was quite satisfactory.

HIGHFIELD AND HAMPSTEAD HOSPITAL — FIRST 2003 INSPECTION

INSPECTED ON 11 JUNE 2003

IN-PATIENT CARE

In-patient care was provided with a total of 85 beds in one male and one female unit.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	1	—	—	5	6	7.7
3-12 Months	—	—	—	3	3	3	9	11.5
1-5 Years	—	—	—	4	16	22	42	53.9
> 5 Years	—	—	—	4	4	13	21	26.9
All Lengths of Stay	—	—	1	11	23	43	78	100
% of Total	—	—	1.3	14.1	29.5	55.1	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	13	4	9	2	1
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified*	All Diagnoses
—	—	—	2	47	78

*Vascular Dementia/Alzheimer's Disease

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	40	40	80
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court*	4	5	9
Total	40	40	80

*Included in Voluntary patients

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
28	—	N/A	N/A	100	—	15	8

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
3	9	164*	45	1

*140 Nurse Assistants

HIGHFIELD HOSPITAL

Highfield Hospital catered for female patients and accommodated 40 patients ranging in age from 50 to 92 years; five were wards of court and the remainder were of voluntary status. During 2002, there were 23 admissions to Highfield Hospital; 16 patients were discharged and eight patients died. Total staffing consisted of four nurses and 22 nurses-aides. At the time of inspection, staffing comprised one nurse and seven aides by day and one nurse and four aides by night.

Despite the sparsity of nurses on the rotas, the standards of hygiene and cleanliness were excellent. The patients clothing, all bed clothing, and towelling etc. were of a similar standard. On the left hand side of the foyer was the sitting room; off this room was the activation room where 13 patients actively engaged in various pursuits. To the rear were two dormitories, toilets, bathroom, shower, sluice room and a high-dependency sitting room, which catered for eight patients. During the past year a sluice room had been converted into a lovely visitors' room, next to which was the exit to the high-walled gardens.

The first-floor accommodation comprised a number of bedrooms, toilet facilities and a special dining room that catered for six elderly patients. The top floor consisted of a corridor off which there were nine bedrooms. There was a lift in operation between the various floors. Painting and decorating was in progress and extensive electrical rewiring of the building was also in evidence.

All areas had access to fire escapes. A specified person was dedicated to the practice of evacuation, fire lectures etc. He also provided a similar service to Hampstead Hospital. The senior nurse had responsibility for ordering medicines and for checking the consultant psychiatrist's prescriptions.

HAMPSTEAD HOSPITAL

Forty patients, all male, ranging in age from 50 to 80 years were present on the day of inspection, three were wards of court and 37 were of voluntary status. This unit was similar in design to Highfield, with two corridors and facilities almost identical. The lower corridor accommodated 18 patients, with 19 on the upper corridor, and the remaining three slept in the flatlet which comprised the entire top floor of the original house.

The lower corridor, together with its dormitory, dining and day areas had been painted and decorated since the last inspection; it was also intended to have a bathroom installed at the end of the lower corridor. Staffing consisted of the Director of Nursing, eight nurses including the senior nurse and 18 nurses-aides. Two nurses and six nurses-aides were on duty by day and one nurse and three nurses-aides on duty by night. Unlike Highfield, there was no evidence of therapeutic activities but the patients were very elderly. The standards of hygiene were excellent and the food served at mealtime appeared very appetizing.

The Inspectorate had a discussion with the senior nurse regarding any shortcomings of the service: issues such as quality assurance, risk assessment and management, policies and procedures, guidelines, catering, hospital brochure, notice of patients' rights, complaints procedures, nursing care models, and all procedures in connection with medicines. The hospital was undergoing accreditation through the CASPE organisation. The Director of Nursing had been vigorously implementing new policies in connection with the above. The hospital hoped to have its final accreditation visit carried out towards the end of 2003 and was hopeful of being approved.

The continued registration of Hampstead and Highfield as an approved psychiatric facility under the Mental Treatment Act, 1945 was recommended.

HIGHFIELD AND HAMPSTEAD HOSPITAL -SECOND 2003 INSPECTION

INSPECTED ON 20 NOVEMBER 2003

HIGHFIELD HOSPITAL

Highfield was a large, detached three-storey house in its own spacious grounds and was part of the Highfield, Hampstead, Elmhurst and Alzheimer Unit complex. It was primarily dedicated to the care of the elderly. There were 44 residents and two day patients present on the day of inspection, ranging in age from 54 to 93 years; all were female. Five were wards of court and the remainder were voluntary. Most suffered from organic brain disorder, mostly of Alzheimer type. There were nine patient care staff during the day of whom two were nurses and the remainder nursing aides.

The ground floor accommodation consisted of the sleeping area, day area, which included a smoking room, sitting room, and dining area. There was a conservatory, which served as an occupational facility and which was staffed by art therapists and others who attended on a sessional basis.

Day and sleeping areas were provided on the middle floor, which was locked. This unit catered for some quite disturbed patients who also dined on this floor. Much of the sleeping accommodation was in small rooms, some single rooms but some crowded, with up to four patients. There was further sleeping accommodation on the second floor. There was a chair lift at this level. A new smoking room and also a new visitors' room had been created in recent months.

A psychiatrist attended daily and there was satisfactory general medical cover. The fire prevention and evacuatary procedures were properly catered for and staff had participated in the appropriate exercises.

The general standard of cleanliness, hygiene and comfort were satisfactory.

HAMPSTEAD HOSPITAL

Hampstead Hospital was a free-standing 19th century house. It, too, was primarily dedicated to the care of the elderly. There were 41 male patients present at the time of inspection, mostly in the 60 to 80 years, age bracket; most suffered from organic dementia. Staffing consisted of two nurses and seven nurses' aides by day and one nurse and three aides by night.

Accommodation was arranged on two floors; the main day area and dining room were on the first floor, sleeping accommodation was arranged on either side of the corridor and was mostly in single rooms. There was one five-bed room which had screens and rails around the beds. All clothing was personalised. The ground floor catered for more disturbed patients and it had its own sitting room and sleeping accommodation in a mix of single and larger sleeping units. There was music therapy three times a week. As with

Highfield Hospital, a staff psychiatrist attended daily and there was satisfactory general medical cover.

The general standard of cleanliness, hygiene and comfort were satisfactory.

KYLEMORE CLINIC, DÚN LAOGHAIRE/RATHDOWN

FIRST 2003 INSPECTION

INSPECTED ON 8th APRIL 2003

GENERAL DESCRIPTION OF THE SERVICE

Kylemore Clinic was founded in 1947 to provide in-patient and out-patient care for people with psychiatric and related illnesses. It gradually evolved into a unit catering for later-life psychiatric illness, particularly dementia-type illness such as Alzheimer's disease, though not exclusively so. The Kylemore Clinic was a registered charity and the Management Committee act in a voluntary capacity. The Board met on a monthly basis and the Secretary Manager and the Director of Nursing attended.

IN-PATIENT CARE

In-patient care was provided with a total of 38 beds.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	—	—	—	—	—	—
3-12 Months	—	—	—	1	—	1	2	5.4
1-5 Years	—	—	1	5	2	13	21	56.8
> 5 Years	—	—	—	4	1	9	14	37.8
All Lengths of Stay	—	—	1	10	3	23	37	100
% of Total	—	—	2.7	27.0	8.1	62.2	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
29	3	—	2	2	—
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
—	—	—	—	1	37

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	12	21	33
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	1	3	4
Total	13	24	37

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
3	—	—	—	66.6	33.3	1	1

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
2	1	26.8	9	1

GENERAL COMMENTS

Kylemore Clinic was a large two-storey over-basement property set in its own attractive and well-maintained grounds. As noted previously, some acres of the grounds were sold for private development to generate funds to refurbish the clinic. On the previous visit of inspection, the Inspectorate had understood that, with the money generated from the sale of land a purpose-built unit to cater for approximately 60 patients would be built at the rear of the present house. It was now understood that planning permission had been sought to remodel and adapt it to modern medical care requirements. This planning request was rejected and was now the subject of an appeal. The outcome of this appeal was awaited. It would appear that the public authorities were seeking to have the house listed as a preserved building.

The Inspectorate felt that this house was unsuitable for modern day psychiatry, particularly for elderly patients. The multiplicity of stairs and stairwells made it quite difficult for elderly patients. On the east side was an extension, off which there was a well-used and much-appreciated conservatory. On the west side was a courtyard with buildings which housed the nursing home area, the administrative offices, the occupational therapy department, a staff dining-room area and a flat complex, which was occupied by a young man who suffered from brain pathology. The courtyard served as an assembly area in the event of fire, as fire escapes from the various floors ended there.

There were 37 patients in residence on the day of inspection. Eleven patients were subvented by the ERHA. Most of the other patients had private cover. Seventy-five per cent of the patients suffered from dementia, either of the Alzheimer's or vascular varieties. Staffing consisted of 10 qualified staff nurses and 17 care assistants, 10 nurses and 13 care assistants by day and one nurse and three care assistants by night. The care assistants

received a two-week induction course, which included training in lifting and handling techniques. There was great difficulty recruiting suitable nurses and permanent staff. However, the Director of Nursing was trying to increase the nursing complement by five. There was no social worker attached to this service.

Two consultant psychiatrists, one of which acts as an Honorary Clinical Director provided psychiatric care. The Director of Nursing had greatly increased inputs into physiotherapy, chiropody, musical therapy and occupational therapy. There were also reminiscence-cum-music therapy sessions. Local schoolgirls visited the patients regularly during their transition year and their visits were highly valued.

The drug kardex system was in use and was quite satisfactory and the medications were supplied by the local pharmacist.

All facets of fire precautions appeared satisfactory and lectures and drills had been carried out in the recent past. Individual fire blankets had been introduced for each bed. An extensive evaluation of current service provision and clinical risk assessment had taken place as part of the formation of a detailed development plan.

The overall standard of hygiene, décor and patient care was satisfactory and its continued registration under the Mental Treatment Act, 1945 was recommended.

KYLEMORE CLINIC, DÚN LAOGHAIRE/RATHDOWN

SECOND 2003 INSPECTION

INSPECTED ON 2 DECEMBER 2003

GENERAL COMMENTS

The planning application to demolish the existing building and to build a new Clinic on the site had been refused. The Inspectorate was informed that a modified proposal, with retention of the main house and the provision of new accommodation by extension was being submitted.

Modernisation would be helpful, as the accommodation, which extended over many different levels in sleeping units of various sizes, including several double and single rooms did not make for easy management of care. There was adequate day space, a dining-room and a designated smoking area. Food came from the clinic's own kitchen. The clinic had a laundry facility, which catered for smaller items; bed-linen and associated materials were sent to an outside laundry service.

There were 37 patients in residence on the day of inspection, 24 female and 13 male, four were wards of court and the remainder were voluntary. Eleven patients were aged under 65-years of age and 26 patients were over 75-years of age. Staffing consisted of ten trained nurses and 24 assistants. There was an occupational department in the courtyard which benefited those patients mobile enough to attend.

The general level of care was satisfactory.

PALMERSTOWN VIEW, BUNGALOW 22, STEWART'S HOSPITAL, DUBLIN

FIRST 2003 INSPECTION

INSPECTED ON 31 MARCH 2003

GENERAL DESCRIPTION OF THE SERVICE

Palmerstown View, one of eighteen bungalows on the Stewart's Hospital campus was formally registered as a private charitable institution on 1 March 1979 for the reception of eight patients. This was to replace a domestic-style house situated on the periphery of the campus that had served this purpose for many years and which had since been sold.

IN-PATIENT CARE

In-patient care was provided with a total of eight beds.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	—	—	—	—	—	—
3-12 Months	—	—	—	1	—	—	1	20.0
1-5 Years	—	—	1	—	—	—	1	20.0
> 5 Years	—	—	2	1	—	—	3	60.0
All Lengths of Stay	—	—	3	2	—	—	5	100
% of Total	—	—	60.0	40.0	—	—	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	—	—	—	—	—
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
—	—	—	5	—	5

Status of In-Patients on Date of Inspection 2003

Status	Male	Female	Total
Voluntary	4	1	5
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	4	1	5

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
3	N/A	—	—	100	—	2	—

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
2	—	4*	1	3

*2 Nurse Assistants

GENERAL COMMENTS

Palmerstown View was one of a number of residential-style bungalows in the grounds of Stewart's Hospital. The unit comprised a spacious day area, which was comfortably and appropriately furnished, bedrooms, a dining area and toilet facilities, all of which were to a high standard of hygiene and décor. The Inspectorate welcomed the provision of a suitable en-suite room for a female patient since the last visit of inspection.

There were five patients in residence on the day of inspection. There were three admissions and two discharges from this Unit during 2002.

One male patient was causing some problems because of his challenging behaviour and had to have three-to-four daily periods of varying time in seclusion. The nursing notes examined confirmed that the fifteen-minute nursing observations while the patient was in seclusion had been correctly completed. However, apart from details in the seclusion book itself, the medical clinical notes should reflect the reasons for and the result of each period of seclusion. Otherwise, the quality of the case notes and note-taking of both the medical and nursing staff was of a high standard.

The patients' clothes, bed clothes and toweling etc. were of a high quality and a very friendly ambiance prevailed during the visit.

The continued registration as an approved institution under the Mental Treatment Act, 1945 was recommended.

PALMERSTOWN VIEW, BUNGALOW 22, STEWART'S HOSPITAL —

SECOND 2003 INSPECTION

INSPECTED ON 18 DECEMBER 2003

GENERAL COMMENTS

Palmerstown View specialised in the treatment of "dual diagnosis" patients or those with challenging behaviour.

There were six voluntary patients in the unit on the day of inspection of whom one was female; only one patient was actually on the unit with the remainder either being at the Day Activity Centre or out on a trip on the minibus. Staffing consisted of two nursing staff and two care assistants.

Seclusion was still used and had been a frequent occurrence; however, recently a new policy of giving disturbed patients the freedom of the adjoining grounds to cool down had been adopted and this was having the desired effect. Seclusion entries for prescribing this intervention had been signed, not always legibly, by junior doctors for the most part. Seclusion episodes sometimes were recorded in medical case notes, but not always. Fifteen-minute observations were kept.

The furnishing and decorative order of the building were in good order. There was a personal alarm for staff.

LARCH BUNGALOW, BELMONT PARK HOSPITAL, WATERFORD

FIRST 2003 INSPECTION

INSPECTED ON 25 APRIL 2003

GENERAL DESCRIPTION OF THE SERVICE

Larch Bungalow was one of four similar bungalows on the campus of Belmont Park Hospital. It was the only facility of the hospital that fell within the remit of the Inspectorate as it was an approved-institution under the Mental Treatment Act, 1945.

IN-PATIENT CARE

In-patient care was provided at Larch Bungalow where eight beds were provided for the mental health needs of persons with intellectual disabilities.

Age and Length of Stay of all Patients at 31.12.02

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	—	—	—	—	—	—
3-12 Months	—	—	—	—	—	—	—	—
1-5 Years	—	—	5	1	—	—	6	75.0
> 5 Years	—	—	—	2	—	—	2	25.0
All Lengths of Stay	—	—	5	3	—	—	8	100
% of Total	—	—	62.5	37.5	—	—	100	

In-Patient Population Diagnosis at 31.12.02

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	—	—	—	—	—
Personality Disorder	Alcoholic Disorder	Drug Dependence	Intellectual Disability	Unspecified	All Diagnoses
—	—	—	8	—	8

Status of In-Patients on date of Inspection 2003

Status	Male	Female	Total
Voluntary	5	2	7
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	5	2	7

ADMISSIONS/DISCHARGES AND DEATHS IN 2002

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
—	N/A	N/A	N/A	—	—	—	—

*Per 1,000 population

COMMUNITY FACILITIES**Day Facilities**

	Number	No. of Places	No. of persons attending
Day Hospitals	—	—	—
Day Centres	1	33	33*
Out-patient clinics	—	—	—

*Includes seven people from the psychiatric unit and twenty-seven others with intellectual disabilities.

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
0.24	0.40	5.50	5.45	0.2

GENERAL COMMENTS

Larch Bungalow was a domestic-style bungalow residence on the Belmont Park Hospital Campus. There were eight patients in residence on the day of inspection, the same personnel as on the previous visit of inspection. The unit consisted of a large sitting-room cum dining-room area, six bedrooms, two en-suites, a small laundry area, a kitchen area and a bathroom area consisting of toilet, shower and wash-hand basin. The standard of hygiene was excellent. The new en-suite facilities were greatly appreciated. One area of concern

noted by the Inspectorate was the main toilet area. The lid of the toilet cistern was missing and the shower curtains were falling down and the whole area was drab. However, there were plans to have this area modernised in the immediate future

There was no evidence of challenging behaviour by any patient. Six of the patients spent most of the day in the activity unit on campus, while the remaining two remained in the unit. Apart from the activity unit, all the patients were regularly taken on trips outside the hospital setting.

Seclusion was practiced in this unit. The seclusion room was safe and clean. In 2002, there were 39 episodes of seclusion, involving five patients. Each period of seclusion was authorised by the consultant psychiatrist. The seclusion book and fifteen-minute observation book were properly written up. There was no monitoring camera in evidence.

The Inspectorate checked one case notes at random and noted the detailed recording of the various conference minutes, where all aspects of the patient's care and management was recorded. The attendance at each conference was also impressive, as all members of the multi-disciplinary team attended, as well as the patient's relatives.

The continued registration of Larch Villa as an approved-institution under the Mental Treatment Act, 1945 was recommended.

LARCH BUNGALOW, BELMONT PARK HOSPITAL, WATERFORD

SECOND 2003 INSPECTION

INSPECTED ON 23 NOVEMBER 2003

GENERAL COMMENTS

The eight-bedded unit had a full complement of patients, six male and two female on the day of inspection: two patients were in the 20-30 year age group, four in the 40-50 year age group, one in the 50-60 year age group and the remaining patient was 61 years old. Two of the patients were diagnosed as autistic while a third patient who had a primary diagnosis of Down Syndrome also displayed autistic features. Another patient had his mental disability compounded by epilepsy. Two of the patients were difficult to manage because of their challenging behaviour and this was the main reason for not partaking in therapeutic activities provided by the therapists such as aromatherapy, exercise outdoors on the grounds, indoor games such as bowling, skittles, bingo and rings, music appreciation (sonus), arts and crafts, relaxation therapies, multi-sensory activities, reminiscence therapy, cooking and pastoral activities etc.

Seclusion was used extensively in this unit and there were 150 episodes since April 2003. The length-of-stay in seclusion was only a matter of minutes; nevertheless, its use to such an extent should be reviewed as a matter of some urgency. Episodes of seclusion were prescribed by the consultant psychiatrist but on occasions it was found necessary to accept permission by telephone and this was formally signed by the consultant psychiatrist the

following day. Fifteen-minutes nursing observation were duly recorded in the special nursing observation book provided. Since the last visit some improvements had been noted. The seclusion room has been decorated and the bed which had been considered a hazard was replaced by a bean bag. The bathroom was also being revamped. This work was in progress and the new heavy-duty tiling on floor and walls augurs well for the facility when completed.

Nursing cover was provided by a Clinical Nurse Manager II, assisted by three care staff by day while at night cover was provided by a staff nurse assisted by one care staff. In addition, the night superintendent was based in this unit and if necessary would provide assistance. Psychiatric cover was provided by a consultant psychiatrist and a visiting doctor provides a GP service. Two psychologists and a social worker had inputs here and there was also a recreational therapist and a visiting physiotherapist. The standard of care, hygiene and décor were excellent.

APPENDIX 1

Statistics Relating to the Psychiatric Services

APPENDIX 1

TABLE 1.

Number of Patients in Public Psychiatric Hospitals and Units at 31 December 1998-2003 excluding Older Patients and Patients with an Intellectual Disability in De-Designated Wards.

	1998	1999	2000	2001	2002	2003
EASTERN REGIONAL HEALTH AUTHORITY						
St. Brendan's Hospital, Dublin 7	181	187	177	160	143	133
St. Ita's Hospital, Portrane, County Dublin	507	501	498	452	422	351
St. Vincent's Hospital, Fairview, Dublin 3	72	72	74	72	61	70
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	15	8	17	15	14	15
Psychiatric Unit, Vergemount, Clonskeagh, Dublin 6	25	22	21	19	22	20
Psychiatric Unit, St. James's Hospital, Dublin 8 (1)	89	75	51	47	49	43
Cluain Mhuire Family Centre, Blackrock, County Dublin	46	57	41	34	26	36
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4	20	12	14	10	6	13
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15	15	15	19	15	17	21
Newcastle Hospital, County Wicklow	73	65	63	66	66	51
St. Loman's Hospital, Palmerstown, Dublin 20	74	25	19	20	18	15
Psychiatric Unit, Tallaght Hospital ⁽¹⁾	—	44	38	38	49	39
Lakeview Unit, Naas General Hospital, Naas, County Kildare	28	23	42	33	20	21
Central Mental Hospital, Dundrum, Dublin 14	84	86	79	83	74	74
TOTAL	1,229	1,192	1,153	1,064	987	902
MIDLAND HEALTH BOARD						
St. Fintan's Hospital, Portlaoise	111	91	97	90	81	93
St. Loman's Hospital, Mullingar	192	187	184	181	171	173
TOTAL	303	278	281	271	252	266
MID-WESTERN HEALTH BOARD						
Clare Mental Health Services ⁽²⁾	194	190	187	146	19	16
Acute Psychiatric Unit, Ennis General Hospital	—	—	—	46	51	32
Psychiatric Unit, Limerick Regional Hospital	46	49	53	46	45	36
St. Joseph's Hospital, Limerick	189	187	184	145	153	117
TOTAL	429	426	424	383	268	201
NORTH-EASTERN HEALTH BOARD						
St. Brigid's Hospital, Ardee	130	120	99	94	75	61
Psychiatric Unit, Our Lady's Hospital, Navan	16	15	18	26	22	26
St. Davnet's Hospital, Monaghan	93	81	67	63	60	62
Psychiatric Unit, Cavan General Hospital	21	13	9	11	9	12
TOTAL	260	229	193	194	166	161
NORTH-WESTERN HEALTH BOARD						
Sligo Mental Health Service, Ballytivnan, County Sligo	68	47	59	47	48	51
St. Conal's Hospital, Letterkenny, County Donegal	70	71	36	36	35	35
Psychiatric Unit, Letterkenny General Hospital	53	48	49	50	42	46
TOTAL	191	166	144	133	125	132

	1998	1999	2000	2001	2002	2003
SOUTH-EASTERN HEALTH BOARD						
St. Dymphna's Hospital, Carlow	102	107	95	92	91	65
St. Canice's Hospital — St. Luke's Hospital Kilkenny	132	100	107	77	79	90
St. Luke's Hospital, Clonmel	193	187	170	167	159	163
St. Michael's Unit, Clonmel	43	41	50	45	50	45
St. Otteran's Hospital, Waterford	121	120	120	116	109	116
Psychiatric Unit, Waterford Regional Hospital, Ardkeen	34	21	33	41	33	42
St. Senan's Hospital, Enniscorthy	203	186	195	146	159	156
TOTAL	828	762	770	684	680	677
SOUTHERN HEALTH BOARD						
North Lee Mental Health Services ⁽³⁾	106	107	100	119	119	119
North Cork Mental Health Services ⁽⁴⁾	276	232	217	209	187	180
South Lee Mental Health Services ⁽⁵⁾	70	91	85	99	94	86
Psychiatric Unit, Bantry General Hospital	15	13	12	15	11	9
St. Finan's Hospital, Killarney	209	204	179	145	125	110
Psychiatric Unit, Tralee General Hospital	37	38	48	47	47	38
TOTAL	713	685	641	634	583	542
WESTERN HEALTH BOARD						
St. Brigid's Hospital, Ballinasloe	357	323	280	266	270	235
Psychiatric Unit, U.C.H., Galway	46	47	70	42	68	45
St. Mary's Hospital, Castlebar	191	180	170	138	116	90
Psychiatric Unit, Roscommon County Hospital	24	17	13	8	10	15
TOTAL	618	567	533	454	464	385
OVERALL TOTAL	4,571	4,305	4,139	3,817	3,525	3,266

⁽¹⁾ This figure includes patients under subvention by the Eastern Regional Health Authority in St. Patrick's Catchment Area Services.

⁽²⁾ Our Lady's Hospital, Ennis closed in April 2002.

⁽³⁾ St. Michael's Unit, Mercy Hospital & Carraig Mor.

⁽⁴⁾ St. Stephen's Hospital, Sarsfield Court.

⁽⁵⁾ Psychiatric Unit, Cork University Hospital & St. Finbarr's Hospital.

TABLE 2.

Number of Patients in Public Psychiatric Units and Hospitals, Number of Patients with an Intellectual Disability and Number of Older Patients in De-Designated Facilities at 31 December, 2003.

	Psychiatric	Intellectual Disability (De-Designated)	Older Persons (De-Designated)
EASTERN REGIONAL HEALTH AUTHORITY			
St. Brendan's Hospital, Dublin 7	133	—	—
St. Ita's Hospital, Portrane, County Dublin	351	—	—
St. Vincent's Hospital, Fairview, Dublin 3	70	—	—
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	15	—	—
Psychiatric Unit, Vergemount, Clonskeagh, Dublin 6	20	—	—
Psychiatric Unit, St. James's Hospital, Dublin 8	43	—	—
Cluain Mhuire Family Centre, Blackrock, County Dublin	36	—	—
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4	13	—	—
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15	21	—	70
Newcastle Hospital, County Wicklow	51	—	—
St. Loman's Hospital, Palmerstown, Dublin 20	15	—	29
Psychiatric Unit, Tallaght Hospital	39	—	—
Lakeview Unit, Naas General Hospital, Naas, County Kildare	21	—	—
Central Mental Hospital, Dundrum, Dublin 14	74	—	—
TOTAL	902	0	99
MIDLAND HEALTH BOARD			
St. Fintan's Hospital, Portlaoise	93	45	—
St. Loman's Hospital, Mullingar	173	58	—
TOTAL	266	103	—
MID-WESTERN HEALTH BOARD			
Clare Mental Health Services	16	—	—
Acute Psychiatric Unit, Ennis General Hospital	32	—	—
Psychiatric Unit, Limerick Regional Hospital	36	—	—
St. Joseph's Hospital, Limerick	117	—	—
TOTAL	201	—	—
NORTH-EASTERN HEALTH BOARD			
St. Brigid's Hospital, Ardee, County Louth	61	—	—
Psychiatric Unit, Our Lady's Hospital, Navan	26	—	—
St. Davnet's Hospital, Monaghan	62	28	20
Psychiatric Unit, Cavan General Hospital	12	—	—
TOTAL	161	28	20
NORTH-WESTERN HEALTH BOARD			
Sligo Mental Health Service, Ballytivnan, Sligo	51	—	24
St. Conal's Hospital, Letterkenny	35	—	14
Psychiatric Unit, Letterkenny General Hospital	46	—	—
TOTAL	132	0	38
SOUTH-EASTERN HEALTH BOARD			
St. Dymphna's Hospital, Carlow	65	—	—
St. Canice's Hospital — St. Luke's Hospital, Kilkenny	90	—	—
St. Luke's Hospital, Clonmel	163	—	—
St. Michael's Unit, Clonmel	45	—	—
St. Otteran's Hospital, Waterford	116	—	—
Psychiatric Unit, Waterford Regional Hospital, Ardkeen	42	—	—
St. Senan's Hospital, Enniscorthy	156	—	—
TOTAL	677	0	0

	Psychiatric	Intellectual Disability (De-Designated)	Older Persons (Non Designated)
SOUTHERN HEALTH BOARD			
North Lee Mental Health Services ⁽¹⁾	119	—	—
North Cork Mental Health Services ⁽²⁾	180	8	—
South Lee Mental Health Services ⁽³⁾	86	—	—
Psychiatric Unit, Bantry General Hospital	9	—	—
St. Finan's Hospital, Killarney	110	26	—
Psychiatric Unit, Tralee General Hospital	38	—	—
TOTAL	542	34	—
WESTERN HEALTH BOARD			
St. Brigid's Hospital, Ballinasloe	235	—	—
Psychiatric Unit, U.C.H., Galway	45	—	—
St. Mary's Hospital, Castlebar	90	4	19
Psychiatric Unit, Roscommon County Hospital	15	—	—
TOTAL	385	4	19
OVERALL TOTAL	3,266	169	176

⁽¹⁾ St. Michael's Unit, Mercy Hospital & Carraig Mor.

⁽²⁾ St. Stephen's Hospital, Sarsfield Court.

⁽³⁾ Psychiatric Unit, Cork University Hospital & St. Finbarr's Hospital.

TABLE 3.

Rate of Hospitalisation per 1,000 of the population at 31 December, 2001-2003.

	2001	2002	2003
EASTERN REGIONAL HEALTH AUTHORITY			
St. Brendan's Hospital, Dublin 7	1.0 ⁽¹⁾	0.9 ⁽¹⁾	0.8 ⁽¹⁾
St. Ita's Hospital, Portrane, County Dublin			
St. Vincent's Hospital, Fairview, Dublin 3			
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7			
Psychiatric Unit, Vergemount, Clonskeagh, Dublin 6			
Psychiatric Unit, St. James's Hospital, Dublin 8			
Cluain Mhuire Family Centre, Blackrock, County Dublin			
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4	0.7	0.7	0.5
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15			
Wicklow Mental Health Services			
St. Loman's Hospital, Palmerstown, Dublin 20	0.4	0.3	0.2
Psychiatric Unit, Tallaght Hospital			
Kildare Mental Health Services		0.1	0.1
TOTAL	0.7	0.7	0.6
MIDLAND HEALTH BOARD			
Laois/Offaly Mental Health Services	0.8	0.7	0.7
Longford/Westmeath Mental Health Services	1.9	1.8	1.6
TOTAL	1.3	1.2	1.2
MID-WESTERN HEALTH BOARD			
Clare Mental Health Services	2.0	0.7	0.5
Limerick Mental Health Services	1.2	1.2	0.9
TOTAL	1.5	1.0	0.7
NORTH-EASTERN HEALTH BOARD			
Louth/Meath Mental Health Services	0.6	0.5	0.4
Cavan/Monaghan Mental Health Services	0.7	0.7	0.7
TOTAL	0.6	0.5	0.5
NORTH-WESTERN HEALTH BOARD			
Sligo Mental Health Services	0.6	0.5	0.6
Donegal Mental Health Services	0.7	0.6	0.6
TOTAL	0.6	0.6	0.6
SOUTH-EASTERN HEALTH BOARD			
Carlow Mental Health Services	2.2	2.2	1.4
Kilkenny Mental Health Services	1.3	1.3	1.1
Tipperary Mental Health Services	1.6	1.5	1.5
Waterford Mental Health Services	1.5	1.3	1.4
Wexford Mental Health Services	1.4	1.5	1.3
TOTAL	1.5	1.5	1.4

	2001	2002	2003
SOUTHERN HEALTH BOARD			
North Lee Mental Health Services ⁽²⁾	1.0	1.0	0.9
North Cork Mental Health Services ⁽³⁾			
South Lee Mental Health Services ⁽⁴⁾			
West Cork Mental Health Services			
Kerry Mental Health Services	1.5	1.4	1.1
TOTAL	1.1	1.1	0.9
WESTERN HEALTH BOARD			
East Galway Mental Health Services	1.6	1.8	1.4
West Galway Mental Health Services			
Mayo Mental Health Services			
Roscommon Mental Health Services			
TOTAL	1.3	1.3	1.0
OVERALL TOTAL	1.0	0.9	0.8

⁽¹⁾ Because of the overlap in hospital catchment areas in Dublin and Cork, these hospitals have been grouped together, except St. Loman's Hospital in Dublin for which separate information is available.

⁽²⁾ St. Michael's Unit, Mercy Hospital & Carraig Mor.

⁽³⁾ St. Stephen's Hospital, Sarsfield Court.

⁽⁴⁾ Psychiatric Unit, Cork University Hospital & St. Finbarr's Hospital.

TABLE 4.

Number of Admissions and Admission Rates for the years ending 31 December, 2001-2003.

	2001	2002	2003	Rates per 1,000 of Population		
				2001	2002	2003
EASTERN REGIONAL HEALTH AUTHORITY						
St. Brendan's Hospital, Dublin 7	668	590	561	5.2 ⁽¹⁾	4.7 ⁽¹⁾	4.8 ⁽¹⁾
St. Ita's Hospital, Portrane, County Dublin	894	792	1,028			
St. Vincent's Hospital, Fairview, Dublin 3	719	653	568			
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	240	228	198			
Psychiatric Unit, Vergemount, Clonskeagh, Dublin 6	346	333	271			
Psychiatric Unit, St. James's Hospital, Dublin 8 ⁽²⁾	468	557	552			
Cluain Mhuire Family Centre, Blackrock, County Dublin	417	386	434			
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4	284	169	203	6.5	5.5	5.7
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15	302	261	261			
Newcastle Hospital, County Wicklow	582	495	571			
St. Loman's Hospital, Palmerstown, Dublin 20	40	—	—			
Psychiatric Unit, Tallaght Hospital	660	620	577			
Lakeview Unit, Naas General Hospital, Naas, County Kildare	719	727	601			
TOTAL	6,339	5,811	5,825			
MIDLAND HEALTH BOARD						
St. Fintan's Hospital, Portlaoise	768	688	690	6.9	6.1	5.6
St. Loman's Hospital, Mullingar	844	795	649	8.9	8.4	6.2
TOTAL	1,612	1,483	1,339	7.8	7.2	5.8
MID-WESTERN HEALTH BOARD						
Clare Mental Health Services	502	518	540	5.3	5.5	5.2
Psychiatric Unit, Limerick Regional Hospital	761	712	624	4.7	4.4	3.6
St. Joseph's Hospital, Limerick	7	10	12			
TOTAL	1,270	1,240	1,176	4.9	4.8	4.2
NORTH-EASTERN HEALTH BOARD						
St. Brigid's Hospital, Ardee	420	428	472	3.6	3.5	3.2
Psychiatric Unit, Our Lady's Hospital, Navan	308	277	270			
St. Davnet's Hospital, Monaghan	68	59	76	2.0	1.9	1.9
Psychiatric Unit, Cavan General Hospital	136	134	132			
TOTAL	932	898	950	3.1	3.0	2.8

	2001	2002	2003	Rates per 1,000 of Population		
				2001	2002	2003
NORTH-WESTERN HEALTH BOARD						
Sligo Mental Health Service, Ballytivnan	690	532	471	7.5	5.8	5.3
St. Conal's Hospital, Letterkenny Psychiatric Unit, Letterkenny General Hospital	—	—	—	7.6	6.4	5.8
	921	780	746			
TOTAL	1,611	1,312	1,217	7.5	6.1	5.6
SOUTH-EASTERN HEALTH BOARD						
St. Dymphna's Hospital, Carlow	296	289	63	7.1	6.9	1.4
St. Canice's Hospital — St. Luke's Hospital, Kilkenny	411	417	551	6.8	6.9	6.9
St. Luke's Hospital, Clonmel ⁽³⁾	129	205	205	8.3	8.1	8.0
St. Michael's Unit, Clonmel ⁽³⁾	990	897	886			
St. Otteran's Hospital, Waterford Psychiatric Unit, Waterford Regional Hospital, Ardkeen	43	19	36	7.3	7.4	6.5
	737	768	718			
St. Senan's Hospital, Enniscorthy	585	617	728	5.6	5.9	6.2
TOTAL	3,191	3,212	3,187	7.1	7.2	6.4
SOUTHERN HEALTH BOARD						
North Lee Mental Health Services ⁽⁴⁾	1,171	1,123	1,046			
North Cork Mental Health Services ⁽⁵⁾	349	364	359	5.8 ⁽¹⁾	5.7 ⁽¹⁾	5.2 ⁽¹⁾
South Lee Mental Health Services ⁽⁶⁾	678	658	648			
Psychiatric Unit, Bantry General Hospital	276	265	274			
St. Finan's Hospital, Killarney Psychiatric Unit, Tralee General Hospital	60	62	50	7.1	6.7	6.4
	837	787	792			
TOTAL	3,371	3,259	3,169	6.1	5.9	5.5
WESTERN HEALTH BOARD						
St. Brigid's Hospital, Ballinasloe ⁽⁷⁾ Psychiatric Unit, U.C.H., Galway	655	741	604	7.8	7.2	6.2
	834	648	639			
St. Mary's Hospital, Castlebar Psychiatric Unit, Roscommon County Hospital	664	600	483	6.0	5.4	4.1
	449	387	380	8.5	7.3	7.2
TOTAL	2,602	2,376	2,106	7.3	6.7	5.7
OVERALL TOTAL	20,928	19,591	18,969	5.7	5.3	4.9

⁽¹⁾ Because of the overlap in hospital catchment areas in Dublin and Cork, these hospitals have been grouped together, except St. Loman's Hospital in Dublin for which separate information is available.

⁽²⁾ This figure includes patients under subvention by the Eastern Regional Health Authority in St Patrick's Hospital Service.

⁽³⁾ St. Luke's Hospital and St. Michael's Unit, Clonmel served North and South Tipperary.

⁽⁴⁾ St. Michael's Unit, Mercy Hospital & Carraig Mor.

⁽⁵⁾ St. Stephen's Hospital, Sarsfield Court.

⁽⁶⁾ Psychiatric Unit, Cork University Hospital & St. Finbarr's Hospital.

⁽⁷⁾ St. Brigid's Hospital, Ballinasloe accommodates patients from West Galway.

TABLE 5.

Community Residential Accommodation at 31 December, 2003.

	Number of Community Residences	Number of Places	Places per 100,000 Population	Catchment Area Pop.
EASTERN REGIONAL HEALTH AUTHORITY				840,881
St. Brendan's Hospital, Dublin 7	10	113	} 65	126,656
Psychiatric Unit, James Connolly Memorial Hospital	10	125		
St. Ita's Hospital, Portrane, County Dublin	17	148		202,157
St. Vincent's Hospital, Fairview, Dublin 3/ Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	3	26		138,000
Psychiatric Unit, Vergemount, Clonskeagh, Dublin 6	3	35		10,568
Psychiatric Unit, St. James's Hospital, Dublin 8	7	47		97,000
Cluain Mhuire Family Centre, Blackrock, County Dublin	5	50		172,000
Newcastle Hospital, County Wicklow	10	86		100,004
St. Loman's Hospital, Palmerstown, Dublin 20	13	117		277,229
Lakeview Unit, Naas General Hospital, Naas, County Kildare	6	51		171,196
TOTAL	84	798	57	1,389,310
MIDLAND HEALTH BOARD				
Laois/Offaly Mental Health Services	17	111	89	124,139
Longford/Westmeath Mental Health Services	14	96	91	105,000
TOTAL	31	207	90	229,139
MID-WESTERN HEALTH BOARD				
Clare Mental Health Services	19	217	210	103,277
Limerick Mental Health Services	16	184	105	175,304
TOTAL	35	401	144	278,581
NORTH-EASTERN HEALTH BOARD				
Louth/Meath Mental Health Services	9	98	42	233,668
Cavan/Monaghan Mental Health Services	16	105	96	109,188
TOTAL	25	203	59	342,856
NORTH-WESTERN HEALTH BOARD				
Sligo/Leitrim Mental Health Services	25	177	197	89,648
Donegal Mental Health Services	15	118	91	129,008
TOTAL	40	295	135	218,656
SOUTH-EASTERN HEALTH BOARD				
Carlow Mental Health Services	9	76	165	46,014
Kilkenny Mental Health Services	16	121	151	80,339
Tipperary Mental Health Services	15	80	59	135,620
Waterford Mental Health Services	16	95	82	116,559
Wexford Mental Health Services	13	80	69	116,596
TOTAL	69	452	91	495,128

	Number of Community Residences	Number of Places	Places per 100,000 Population	Catchment Area Pop.
SOUTHERN HEALTH BOARD				447,829
North Lee Mental Health Services ⁽²⁾	8	57	} 47 ⁽¹⁾	156,036
North Cork Mental Health Services ⁽³⁾	6	36		73,511
South Lee Mental Health Services ⁽⁴⁾	7	38		167,479
West Cork Mental Health Services ⁽⁵⁾	9	79		50,803
Kerry Mental Health Services ⁽⁶⁾	17	143	108	132,527
TOTAL	47	353	61	580,356
WESTERN HEALTH BOARD				
East Galway Mental Health Services	46	254	} 158	98,928
West Galway Mental Health Services	12	60		100,000
Mayo Mental Health Services	23	129		117,000
Roscommon Mental Health Services	6	58		52,726
TOTAL	87	501	136	368,654
OVERALL TOTAL	418	3,210	82	3,902,680

⁽¹⁾ Because of the overlap in hospital catchment areas in Dublin and Cork, these areas have been grouped together, except St. Loman's Hospital in Dublin for which separate information is available.

⁽²⁾ St. Michael's Unit, Mercy Hospital & Carraig Mor.

⁽³⁾ St. Stephen's Hospital, Sarsfield Court.

⁽⁴⁾ Psychiatric Unit, Cork University Hospital & St. Finbarr's Hospital.

⁽⁵⁾ Psychiatric Unit, Bantry General Hospital.

⁽⁶⁾ Psychiatric Unit, Tralee General Hospital.

TABLE 6.

Psychiatric In-Patients in Registered Psychiatric Hospitals at 31 December, 2000-2003.

	2000	2001	2002	2003
Bloomfield Hospital, Dublin	44	36	43	41
Palmerstown View, Stewart's Hospital, Dublin	4	4	5	5
Hampstead and Highfield Hospitals, Dublin	71	80	78	80
Kylemore Clinic, Dun Laoghaire/Rathdown	37	37	37	38
Larch Bungalow, Belmont Park, Waterford	7	8	8	8
St. John of God Hospital, Dun Laoghaire/ Rathdown	87	83	94	82
St. Patrick's Hospital, Dublin (inc. St. Edmundsbury)	133	191	176	181
TOTAL	383	439	441	435

INSPECTORATE OF MENTAL HOSPITALS

SECLUSION RECORD 2003

EASTERN REGIONAL HEALTH AUTHORITY**NORTHERN AREA HEALTH BOARD**

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
St. Brendan's Hospital	854	82
St. Ita's Hospital	186	64
St. Joseph's Mental Handicap Services	136	15
St. Vincent's Hospital, Fairview, Dublin 3	70	22
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	34	15
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15	0	0
Total	1,280	198

EAST COAST AREA HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
Psychiatric Unit, Vergemount, Clonskeagh, Dublin 6	0	0
Newcastle Hospital, Co. Wicklow	103	19
Central Mental Hospital	413	111
St. John of God, Stillorgan & Area Service 1	491	36
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4	0	0
Total	1,007	166

SOUTH-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
St. James's Hospital	0	0
St. Loman's Hospital, Palmerstown, Dublin 20	0	0
Psychiatric Unit, Tallaght Hospital	92	40
Kildare MHS Lakeview Unit	107	35
St. Patrick's Hospital & St. Edmundsbury	0	0
Hampstead Private	0	0
Total	199	75

MIDLAND HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
St. Fintan's Hospital, Portlaoise	15	8
St. Loman's Hospital, Mullingar	1	1
Total	16	9

MID-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
Clare Mental Health Services	102	20
Limerick Mental Health Services	40	9
Total	142	29

NORTH-EASTERN HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
St. Brigid's Hospital, Ardee	0	0
Psychiatric Unit, Our Lady's Hospital, Navan	51	12
St. Davnet's Hospital, Monaghan	0	0
Psychiatric Unit, Cavan General Hospital	0	0
Total	51	12

NORTH-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
Sligo Mental Health Service, Ballytivan, County Sligo	51	9
St. Conal's, Letterkenny, County Donegal	0	0
Psychiatric Unit, Letterkenny General Hospital	0	0
Total	51	9

SOUTH-EASTERN HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
St. Dymphna's Hospital, Carlow ⁽¹⁾	257	7
St. Canice's Hospital — St. Luke's Hospital, Kilkenny	24	9
St. Luke's Hospital, Clonmel	174	33
St. Michael's Unit, Clonmel	170	52
St. Otteran's Hospital, Waterford	10	3
Psychiatric Unit, Waterford Regional Hospital, Ardkeen	20	10
St. Senan's Hospital, Enniscorthy	56	9
Total	711	123

SOUTHERN HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
North Lee Mental Health Service ⁽²⁾	0	0
North Cork Mental Health Service ⁽³⁾	0	0
South Lee Mental Health Service ⁽⁴⁾	0	0
Psychiatric Unit, Bantry General Hospital	0	0
St. Finan's Hospital, Killarney	36	9
Psychiatric Unit, Tralee General Hospital	22	14
Total	58	23

WESTERN HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
St. Brigid's Hospital, Ballinasloe	67	6
University College Hospital, Galway	0	0
St. Mary's Hospital, Castlebar	3	2
Psychiatric Unit, Roscommon County Hospital	0	0
Total	70	8

	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
Eastern Regional Health Authority	2,486	439
Midland Health Board	16	9
Mid-Western Health Board	142	29
North Eastern Health Board	51	12
North Western Health Board	51	9
South Eastern Health Board	711	123
Southern Health Board	58	23
Western Health Board	70	8
Total	3,585	652

⁽¹⁾ St. Dymphna's Hospital seclusions figures are for January 2003 — March 2003.

⁽²⁾ St. Michael's Unit, Mercy Hospital & Carraig Mor.

⁽³⁾ St. Stephen's Hospital, Sarsfield Court.

⁽⁴⁾ Psychiatric Unit, Cork University Hospital & St. Finbarr's Hospital.

INSPECTORATE OF MENTAL HOSPITALS

PRESCRIPTION OF ELECTRO CONVULSIVE THERAPY — NUMBER OF PATIENTS — 2003

EASTERN REGIONAL HEALTH AUTHORITY**NORTHERN AREA HEALTH BOARD**

Hospital & In-Patient Unit	E.C.T.
St. Brendan's Hospital	7
St. Ita's Hospital	26
St. Joseph's Mental Handicap Services	0
St. Vincent's Hospital, Fairview, Dublin 3	24
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	7
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15	1
Total	65

EAST COAST AREA HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
Psychiatric Unit, Vergemount, Clonskeagh, Dublin 6	40
Newcastle Hospital, Co. Wicklow	25
Central Mental Hospital	2
St. John of God, Stillorgan & Area Service 1	11
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4	6
Total	84

SOUTH-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
St. James's Hospital	7
St. Loman's Hospital, Palmerstown, Dublin 20	0
Psychiatric Unit, Tallaght Hospital	38
Kildare MHS Lakeview Unit	18
St. Patrick's Hospital & St. Edmundsbury	141
Hampstead Private	0
Total	204

MIDLAND HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
St. Fintan's Hospital, Portlaoise	4
St. Loman's Hospital, Mullingar	16
Total	20

MID-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
Clare Mental Health Services	7
Limerick Mental Health Services	35
Total	42

NORTH EASTERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
St. Brigid's Hospital, Ardee	16
Psychiatric Unit, Our Lady's Hospital, Navan	17
St. Davnet's Hospital, Monaghan	7
Psychiatric Unit, Cavan General Hospital	9
Total	49

NORTH-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
Sligo Mental Health Service, Ballytivan, County Sligo	5
St. Conal's, Letterkenny, County Donegal	0
Psychiatric Unit, Letterkenny General Hospital	11
Total	16

SOUTH-EASTERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
St. Dymphna's Hospital, Carlow	0
St. Canice's Hospital — St. Luke's Hospital, Kilkenny	12
St. Luke's Hospital, Clonmel	0
St. Michael's Unit, Clonmel	30
St. Otteran's Hospital, Waterford	
Psychiatric Unit, Waterford Regional Hospital, Ardkeen	54
St. Senan's Hospital, Enniscorthy	(includes St. Otteran's) 29
Total	125

SOUTHERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
North Lee Mental Health Service ⁽¹⁾	9
North Cork Mental Health Service ⁽²⁾	3
South Lee Mental Health Service ⁽³⁾	9
Psychiatric Unit, Bantry General Hospital	0
St. Finan's Hospital, Killarney	1
Psychiatric Unit, Tralee General Hospital	16
Total	38

WESTERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
St. Brigid's Hospital, Ballinasloe	51
University College Hospital, Galway	34
St. Mary's Hospital, Castlebar	17
Psychiatric Unit, Roscommon County Hospital	4
Total	106

Health Board	E.C.T.
Eastern Regional Health Authority	353
Midland Health Board	20
Mid-Western Health Board	42
North Eastern Health Board	49
North Western Health Board	16
South Eastern Health Board	125
Southern Health Board	38
Western Health Board	106
Total	749

⁽¹⁾ St. Michael's Unit, Mercy Hospital & Carraig Mor.

⁽²⁾ St. Stephen's Hospital, Sarsfield Court.

⁽³⁾ Psychiatric Unit, Cork University Hospital & St. Finbarr's Hospital.

INSPECTORATE OF MENTAL HOSPITALS

SPECIAL NURSING RECORD 2003

EASTERN REGIONAL HEALTH AUTHORITY**NORTHERN AREA HEALTH BOARD**

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
St. Brendan's Hospital	410	19
St. Ita's Hospital	211	11
St. Joseph's Mental Handicap Services	995	6
St. Vincent's Hospital, Fairview, Dublin 3	0	0
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	30	10
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15	344	41
Total	1,990	87

EAST COAST AREA HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
Psychiatric Unit, Vergemount, Clonskeagh, Dublin 6	709	59
Newcastle Hospital, Co. Wicklow	62	14
Central Mental Hospital	464	16
St. John of God, Stillorgan & Area Service 1	76	1
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4	365	40
Total	1,676	130

SOUTH-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
St. James's Hospital	441	10
St. Loman's Hospital, Palmerstown, Dublin 20	0	0
Psychiatric Unit, Tallaght Hospital	1,267	10
Kildare MHS Lakeview Unit	111	15
St. Patrick's Hospital & St. Edmundsbury	129	3
Hampstead Private	3	1
Total	1,951	39

MIDLAND HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
St. Fintan's Hospital, Portlaoise	12	5
St. Loman's Hospital, Mullingar	143	12
Total	155	17

MID-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
Clare Mental Health Services	275	29
Limerick Mental Health Services	3,935	100
Total	4,210	129

NORTH-EASTERN HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
St. Brigid's Hospital, Ardee	747	7
Psychiatric Unit, Our Lady's Hospital, Navan	459	8
St. Davnet's Hospital, Monaghan	14	2
Psychiatric Unit, Cavan General Hospital	4	1
Total	1,224	18

NORTH-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
Sligo Mental Health Service, Ballytivan, County Sligo	599	38
St. Conal's, Letterkenny, County Donegal	0	0
Psychiatric Unit, Letterkenny General Hospital	656	34
Total	1,255	72

SOUTH-EASTERN HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
St. Dymphna's Hospital, Carlow ⁽¹⁾	131	6
St. Canice's Hospital — St. Luke's Hospital, Kilkenny	369	2
St. Luke's Hospital, Clonmel	1,446	36
St. Michael's Unit, Clonmel	288	19
St. Otteran's Hospital, Waterford	5	2
Psychiatric Unit, Waterford Regional Hospital, Ardkeen	6	2
St. Senan's Hospital, Enniscorthy	559	18
Total	2,804	85

SOUTHERN HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
North Lee Mental Health Service ⁽²⁾	102	9
North Cork Mental Health Service ⁽³⁾	539	29
South Lee Mental Health Service ⁽⁴⁾	200	12
Psychiatric Unit, Bantry General Hospital	100	3
St. Finan's Hospital, Killarney	7	1
Psychiatric Unit, Tralee General Hospital	180	15
Total	1,128	69

WESTERN HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
St. Brigid's Hospital, Ballinasloe	944	29
University College Hospital, Galway	456	228
St. Mary's Hospital, Castlebar	739	8
Psychiatric Unit, Roscommon County Hospital	149	21
Total	2,288	286

	Spans of Special Nursing	No. of Patients on Special Nursing
Eastern Regional Health Authority	5,617	256
Midland Health Board	155	17
Mid-Western Health Board	4,210	129
North Eastern Health Board	1,224	18
North Western Health Board	1,255	72
South Eastern Health Board	2,804	85
Southern Health Board	1,128	69
Western Health Board	2,288	286
Total	18,681	932

⁽¹⁾ St. Dymphna's Hospital figures are for January 2003 — March 2003.

⁽²⁾ St. Michael's Unit, Mercy Hospital & Carraig Mor.

⁽³⁾ St. Stephen's Hospital, Sarsfield Court.

⁽⁴⁾ Psychiatric Unit, Cork University Hospital & St. Finbarr's Hospital.

N/A Not available from the Service Provider.

INSPECTORATE OF MENTAL HOSPITALS

INVOL ADM, EXTNS, REGS 2003

EASTERN REGIONAL HEALTH AUTHORITY**NORTHERN AREA HEALTH BOARD**

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
St. Brendan's Hospital	94	70	21	8	0
St. Ita's Hospital	75	28	7	6	0
St. Joseph's Mental Handicap Services	2	0	0	0	0
St. Vincent's Hospital, Fairview, Dublin 3	111	22	18	5	0
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	21	0	3	3	0
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15	20	0	0	0	0
Total	323	120	49	22	0

EAST COAST AREA HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
Psychiatric Unit, Vergemount, Clonskeagh, Dub- lin 6	27	0	7	11	0
Newcastle Hospital, Co. Wicklow	47	6	7	6	0
Central Mental Hospital	127	10	0	0	0
St. John of God, Stillorgan & Area Service 1	40	2	31	0	0
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4	12	0	4	4	0
Total	253	18	49	21	0

SOUTH-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
St. James's Hospital	44	2	10	3	0
St. Loman's Hospital, Palmerstown, Dublin 20	0	0	0	0	0
Psychiatric Unit, Tallaght Hospital	85	0	0	0	0
Kildare MHS Lakeview Unit	79	21	14	10	0
St. Patrick's Hospital & St. Edmundsbury	50	0	0	0	0
Hampstead Private	0	0	0	0	0
Total	258	23	24	13	0

MIDLAND HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
St. Fintan's Hospital, Portlaoise	42	1	5	28	0
St. Loman's Hospital, Mullingar	61	16	14	10	0
Total	103	17	19	38	0

MID-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
Clare Mental Health Services	79	4	18	12	0
Limerick Mental Health Services	106	10	29	16	12
Total	185	14	47	28	12

NORTH-EASTERN HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
St. Brigid's Hospital, Ardee	38	14	8	19	0
Psychiatric Unit, Our Lady's Hospital, Navan	35	2	7	4	0
St. Davnet's Hospital, Monaghan	21	2	3	4	0
Psychiatric Unit, Cavan General Hospital	28	3	3	5	0
Total	122	21	21	32	0

NORTH-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
Sligo Mental Health Service, Ballytivan, County Sligo	67	11	14	32	23
St. Conal's, Letterkenny, County Donegal	4	8	2	4	0
Psychiatric Unit, Letterkenny General Hospital	79	3	25	37	0
Total	150	22	41	73	23

SOUTH-EASTERN HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
St. Dymphna's Hospital, Carlow ⁽¹⁾	4	8	1	4	0
St. Canice's Hospital — St. Luke's Hospital, Kilkenny	34	14	11	15	0
St. Luke's Hospital, Clonmel	45	4	3	4	1
St. Michael's Unit, Clonmel	108	2	17	12	0
St. Otteran's Hospital, Waterford	6	0	2	1	0
Psychiatric Unit, Waterford Regional Hospital, Ardkeen	53	11	11	8	1
St. Senan's Hospital, Enniscorthy	50	10	15	26	0
Total	300	49	60	70	2

SOUTHERN HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
North Lee Mental Health Service ⁽²⁾	190	2	17	60	0
North Cork Mental Health Service ⁽³⁾	26	9	13	21	0
South Lee Mental Health Service ⁽⁴⁾	102	0	27	85	0
Psychiatric Unit, Bantry General Hospital	24	0	20	10	0
St. Finan's Hospital, Killarney	35	17	0	3	0
Psychiatric Unit, Tralee General Hospital	73	1	21	9	0
Total	450	29	98	188	0

WESTERN HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
St. Brigid's Hospital, Ballinasloe	120	23	10	23	51
University College Hospital, Galway	73	0	23	3	0
St. Mary's Hospital, Castlebar	58	4	8	26	2
Psychiatric Unit, Roscommon County Hospital	41	0	6	3	1
Total	292	27	47	55	54

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
Eastern Regional Health Authority	834	161	122	56	0
Midland Health Board	103	17	19	38	0
Mid-Western Health Board	185	14	47	28	12
North Eastern Health Board	122	21	21	32	0
North Western Health Board	150	22	41	73	23
South Eastern Health Board	300	49	60	70	2
Southern Health Board	450	29	98	188	0
Western Health Board	292	27	47	55	54
Total	2,436	340	455	540	91

⁽¹⁾ St. Dymphna's Hospital figures are for January 2003 — March 2003.

⁽²⁾ St. Michael's Unit, Mercy Hospital & Carraig Mor.

⁽³⁾ St. Stephen's Hospital, Sarsfield Court.

⁽⁴⁾ Psychiatric Unit, Cork University Hospital & St. Finbarr's Hospital.

APPENDIX 2

Procedures for Transfers under Section 208

APPENDIX 2

SECTION 208 OF THE MENTAL TREATMENT ACT, 1945 PROCEDURES FOR THE TRANSFER, EXTENSION OF TRANSFER AND DISCHARGE OF PATIENTS

1. PROCEDURES FOR TRANSFER

- 1.1 A health board or a Clinical Director acting on its behalf or the authority of a registered psychiatric hospital may seek the transfer of a detained patient in need of specialist treatment under Section 208 of the Mental Treatment Act 1945 to the Central Mental Hospital, Dundrum, subject to the following conditions:
- (i) that an application for admission is completed on the prescribed form (copy attached);
 - (ii) that the patient has been assessed by his/her Consultant Psychiatrist as being in need of specialist treatment which is not available locally and which in the opinion of the Consultant Psychiatrist can more appropriately be provided in the Central Mental Hospital;
 - (iii) that the patient has been assessed by the person in charge (Clinical Director/RMS/Chief Psychiatrist) as being in need of specialist treatment which is not available locally and which in the opinion of the person in charge can more appropriately be provided in the Central Mental Hospital. If the patient is under the clinical care of the person in charge, he or she should arrange for a second opinion by another consultant psychiatrist;
 - (iv) that the patient has been assessed by the Clinical Director of the Central Mental Hospital as in need of specialist treatment which is not available locally and which in his/her opinion can more appropriately be provided in the Central Mental Hospital;
 - (v) that the patient and the patient's next-of-kin have been informed by the Consultant Psychiatrist of the referring hospital of the proposed transfer at least 24 hours before the transfer takes place and of their rights under the Mental Treatment Act and their right to have their case investigated by the Inspectorate of Mental Hospitals. As far as is practicable the wishes of the patient and the patient's next-of-kin should be accommodated;
 - (vi) that the Inspectorate of Mental Hospitals has been informed of the proposed transfer;
 - (vii) when all of these steps have been completed, the patient may be transferred to the Central Mental Hospital within a period of four days; it is a matter for the health board or hospital authority applying for the admission to arrange transport to the Central Mental Hospital;
 - (viii) following the admission of the patient to the Central Mental Hospital, a copy of the completed application form should be forwarded to the Inspectorate of Mental Hospitals by the Clinical Director of the Central Mental Hospital.

2. LENGTH OF TRANSFER FOR TREATMENT

- 2.1 A patient may only be treated in the Central Mental Hospital under Section 208 of the Mental Treatment Act if he or she is legally detained in his or her parent hospital. **It will be the responsibility of the Clinical Director of the referring service to ensure that the legal requirements in relation to the detention of a patient referred to Dundrum for specialist treatment are met.**
- 2.2 The initial length of the transfer for treatment in the Central Mental Hospital will be 28 days. It will be a matter for the Clinical Director of the Central Mental Hospital to decide whether the patient requires an extension of a period of treatment at the Central Mental Hospital. A period of treatment of 28 days there may be extended to three months, which may be renewed for further periods of three months. The Clinical Director of the Central Mental Hospital will notify the Inspectorate of Mental Hospitals and the referring Clinical Director/RMS/Chief Psychiatrist of each extension of a period of treatment. It is the responsibility of the latter to ensure that the legal requirements in relation to the detention of the patient are met.
- 2.3 On the completion of each period of treatment under Section 208 (i.e. initial 28 days followed by each three month extension), a further treatment plan will be prepared and forwarded to the Inspectorate of Mental Hospitals.

- 2.4 A summary of all treatment plans prepared by the Central Mental Hospital shall be forwarded to the patient's referring consultant who will in turn inform the patient's General Practitioner.

3. DISCHARGE FROM CENTRAL MENTAL HOSPITAL

- 3.1 If the Clinical Director of the Central Mental Hospital decides that a patient no longer requires the specialist treatment available in the Central Mental Hospital, no clinical basis will exist for the patient's continued stay in the Central Mental Hospital and he or she will be transferred back to his/her referring hospital.
- (i) The Clinical Director of the Central Mental Hospital shall inform in writing the Clinical Director/R.M.S./Chief Psychiatrist of the referring hospital of the proposal to transfer back the patient to his/her referring hospital. A copy of this letter shall be forwarded to the Inspectorate of Mental Hospitals for his information.
 - (ii) A copy of all treatment plans prepared by the Central Mental Hospital shall be forwarded to the Clinical Director/R.M.S./Chief Psychiatrist of the referring hospital.
 - (iii) The Clinical Director/R.M.S./Chief Psychiatrist will be responsible for ensuring that the legal requirements in relation to the continued detention of the patient are met.
 - (iv) When all of these steps have been completed, the patient may be transferred back to the parent hospital within a period of seven days; it is a matter for the health board or hospital authority of the referring hospital to arrange for transport.
 - (v) The patient shall be informed by the Clinical Director of the Central Mental Hospital and the patient's next of kin shall be informed by the Consultant Psychiatrist of the referring hospital of the proposed transfer at least 24 hours before the transfer takes place.

**TRANSFER OF PATIENT UNDER SECTION 208,
MENTAL TREATMENT ACT, 1945**

Application from _____ Clinical Director/R.M.S./Chief Psychiatrist acting on behalf of _____ Health Board or the authority of a registered psychiatric hospital to the Clinical Director of the Central Mental Hospital to admit a patient under Section 208, Mental Treatment Act, 1945 to the Central Mental Hospital.

1. Particulars of patient:—

Name _____

Gender _____ Date of Birth _____

Home Address _____

Referring Hospital _____

Referring Consultant Psychiatrist _____

Legal Status under Mental Treatment Act 1945 _____

Next of kin:—

Name _____

Address _____

Telephone _____

2. Recommendation of **Consultant Psychiatrist**

I have assessed _____ (patient's name), a patient under my charge, as being in need of specialist psychiatric treatment which is not available locally and which in my opinion can more appropriately be provided in the Central Mental Hospital.

Signature: _____ Date: _____

3. Recommendation of **Clinical Director/RMS/Chief Psychiatrist**

I have assessed _____ (patient's name) who is a patient of Dr. _____ (name of consultant in charge of patient) as being in need of specialist psychiatric treatment which is not available locally and which in my opinion can more appropriately be provided in the Central Mental Hospital.

I also certify that I have examined the original reception order which is kept at _____ (hospital) details of which are as follows:—

Date of original reception order _____ number of extensions _____

Expiry date of current reception/temporary order _____

Signature: _____ Date: _____

4. Recommendation of **Clinical Director of the Central Mental Hospital**

I have assessed _____ (patient's name) as being in need of specialist psychiatric treatment now which is not available locally and which in my opinion can more appropriately be provided in the Central Mental Hospital.

Signature: _____ Date: _____

5. **Information to Next-of-Kin**

On _____ (date) I, being Consultant Psychiatrist to _____ (patient's name) informed the patient's next-of-kin, _____ (name) of the proposed transfer and of their rights under the Mental Treatment Act, 1945.

Signature: _____ Date: _____

6. Actual date of transfer to the Central Mental Hospital _____

A copy of this completed application form should be sent to the Inspectorate of Mental Hospitals, Department of Health and Children, Hawkins House, Dublin 2.